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Wilbert W. Lewis, Ed.D.

Child Advocacy and Ecological Planning

The nationwide child advocacy system recommended by the Joint Commission on Mental Health of Children cannot be implemented within the next several years. We can, however, begin small demonstration programs that will allow us to develop a conceptual framework, the role models and administrative structures that will be necessary to guarantee whatever services are needed to allow all children in a neighborhood to experience normal, healthy development. The specific plan proposed here is based on a model of ecological planning and utilizes three sequential stages: (1) crisis intervention; (2) outreach into the community; and (3) full child advocacy to implement that objective.

The Joint Commission on Mental Health of Children has made as its major recommendation the development of an elaborate nationwide network of child advocacy that will insure to every child whatever services, programs and resources may be required to facilitate his normal development. It is a bold and innovative idea. The structure of its implementation would include agencies at the federal, state, community and neighborhood levels with a broad mandate to see that appropri-

ate health, mental health, educational and welfare services are available as needed in order to avoid or mitigate developmental problems of all kinds. The neighborhood Child Development Council would be the heart of the advocacy system. It would be responsible for monitoring the progress of each child in its jurisdiction, making referrals to service agencies, evaluating the

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The author wishes to express appreciation to the members of the Joint Planning Committee representing the U.S. Office of Education and NIMH who have provided both stimulation and helpful feedback in evolving a plan for school-based child advocacy. This does not, of course, imply any endorsement of the idea by either agency.

effectiveness and availability of services, and introducing new programs as needed with Federal funds. While this aspiration is praiseworthy, such a massive program seems unlikely to be implemented for a number of reasons:

- (1) *The financial resources required, estimates range from 5 to 8 billion dollars a year, do not reflect our current national priorities for children's programs relative to national defense, space, etc.*
- (2) *The policy of the present administration to move responsibility for planning and financing back to states and cities does not allow for the initiation of such a major new program by the federal government within the next several years.*
- (3) *An important criticism of the Joint Commission recommendation is that it does not give sufficient emphasis to programs for children who are already seriously disturbed and for whom insufficient treatment resources are available. Many mental health professionals argue that this situation should be corrected before beginning preventive programs.*
- (4) *We have at present no group of professional persons with the kind of background that would allow them to plan a nationwide child advocacy program; nor indeed have we even any conceptual framework to guide such planning.*
- (5) *Neighborhood Child Development Centers would introduce still another institutional form into communities that would have uncertain jurisdiction over, and compete for funds with, agencies already serving children.*

In spite of these problems the idea of child advocacy is appealing and deserves to be evaluated in careful demonstrations. There is, at present, no group that feels responsible for the welfare of all children in a neighborhood. Parents feel, and exhibit, a wide range of responsibility for their own children. Service agencies either make a judgment about the appropriate-

ness of a child for their services or are required to restrict their attention based on criteria such as age or family income. A child, for example, who is expelled from school and who is not retarded enough for special education, not old enough for vocational rehabilitation, not delinquent enough for the juvenile courts, etc. may simply not be served, educationally or otherwise by existing community agencies. Or what is more deplorable, the community may provide a terribly inappropriate service out of desperation, such as placement of a child needing residential care on a state hospital ward with psychotic adults because there is no other facility available.

How might we best begin to work toward programs of child advocacy, assuming that the beginnings must be modest, making use principally of resources already present in our communities, that we must attend to improving treatment as well as prevention, and that we must provide ourselves an opportunity to learn before moving into community-wide programs affecting the whole range of services for children? While no existing social institution, in its present form, is ideally suited to provide the coordinating and planning functions implied in the idea of child advocacy, the public elementary school may have great potential because of its location, the clear definition of a population of children it serves and by generally positive attitudes of citizens toward public education. Education would need to be redefined as total facilitation of children's development from infancy on. While the school and its advocacy system would not necessarily provide all of the services that children need, ranging from nutrition through treatment for seriously disturbed children, it could provide monitoring and coordination.

Developing Child Advocacy in a School

The following is an outline of the way a program of child advocacy might be developed in a single public elementary school. It assumes that there is already in the community a range of services for children that vary in quality and could be improved by coordination and consultation. It also assumes that some needed services will be missing and that realistic assessment of what is needed can be made only by those who are intimately involved with obtaining services for children in that particular community.

Three stages of development are envisioned in making a gradual transition from presently available services for children to the full range of activities that would be encompassed by a school-based advocacy system concerned with the identification of children's problems, with availability of community resources and with correcting deficiencies in those resources. The three stages are: (1) Crisis intervention on behalf of children identified as deviant by the school, mental health center, juvenile court and public welfare agency. The initial stage emphasizes effective utilization of treatment resources already available in the community; (2) Outreach into the community to families, recreation programs, pre-schools and other formal child-socialization programs with emphasis on early identification, prevention and initiation of new treatment resources identified as missing in stage one; (3) Child advocacy programs, including new services aimed at facilitating the normal development of all children in the community. While the activities of stages one and two will be continued, the emphasis in stage three is on intervention at the level of social systems serving children, both by

modification of existing systems and the addition of new ones as suggested by feedback from earlier stages. No exact timetable is proposed, but for purposes of discussion one might think of about two years for each of the first two stages, moving into child advocacy programs only in the fifth or sixth year.

The organization of such a program is probably beyond the current resources of most public schools. It may be necessary to develop a consortium of different types of social institutions; a public school, parents and citizen groups, a university with training and research resources, a mental health center, etc., depending on the particular array of resources in a community. Membership in the consortium would imply a commitment of resources and personnel to the development of child advocacy appropriate for a particular community, and membership might change from time to time as organizational goals changed.

A Conceptual Framework

A special problem in articulating the efforts of workers from the several professional disciplines concerned with children is that of developing a common frame of reference. The language of mental health is concerned with deviant behavior and does not serve well in education. The language of education is concerned with typical development of perceptual and cognitive skills and does not serve well in social welfare, and so on. We need a broader conceptual framework to maximize the effectiveness of unique professional contributions and minimize confusion among collaborators who do not share a common background of training and experience.

Education would need to be redefined as total facilitation of children's development from infancy on.

A number of mental health and education programs have recently borrowed from field biology the concept of "ecosystem" as a way of conceptualizing about service programs for children. While the biologist is concerned about hydrological cycles, mineral cycles and energy transmission in an ecosystem, the social scientist is concerned with communication of attitudes, expectations, and evaluations among the members of the social systems to which an individual belongs. The idea has been especially helpful in thinking through programs to provide service for emotionally disturbed children by suggesting more variable treatment strategies than are ordinarily used and may be expanded to carry the larger burden of a conceptual framework for child advocacy.

Typically, a child who is called emotionally disturbed has a rather long history of behaviors that depart in important ways from expectations held for him by the important adults in his life who feel responsible for his socialization. Typically, too, he has been examined by a pediatrician, a school psychologist, or the staff of a mental health center or social work agency and they have confirmed the judgment that his behavior is significantly deviant, i.e., he is "emotionally disturbed". It is at this point that one may choose to make an ecological analysis of the problem that will often have implications for more than one child-serving agency.

We begin with the ecosystem to which a child belongs, which means the usual behavior settings and significant people with whom he interacts on a regular basis. For most children this includes home, school, informal peer groups and sometimes more organized group activities such as a boys'

club or a community recreation center. As an abstraction, the ecosystem is difficult to define but for an individual child the definition is made simply by inquiring where and with whom he spends his time. In his natural behavior settings, parents, teachers, peers and others make judgments about how well he is meeting the expectations held for his behavior. To the extent that there are clear and continuing discrepancies in highly valued areas of behavior, there is "discordance" in the ecosystem. Discordance is usually expressed as too much or too little of some expected behavior: "He has an explosive temper, fights at the drop of a hat" (from a parent); "He's so restless, can't settle down to work on an assignment" (from a teacher); or "He picks on the little kids all the time" (from a peer). An ecological analysis considers each source of discordance as a possible target for intervention, based on the general strategy of increasing the effectiveness of the whole ecosystem by solving a number of small problems, each of which alone might be considered of little consequence. Discordance may be reduced in two ways. First, of course, the child's competence in highly valued areas of behavior may be increased so that he meets more of the expectations held for him. Second, the expectations held for him by important members of his ecosystem and opportunities for him to function effectively there may be modified by working directly in those behavior settings where problems usually occur to achieve a better match between the requirements of behavior setting and child behavior.

The details of a program for a child based on such an analysis will be diverse and may call upon skills from a variety of

professional and non-professional backgrounds: training in perceptual-motor skills for a reading disability; supportive counseling for a mother with unrealistic academic expectations; a "big brother" relationship with an older student; instruction for parents in behavior management; consultation with a teacher in using specialized curriculum materials; help for a father in obtaining employment, etc., depending on the type of discordance identified and its location in a child's ecosystem. The same framework might be employed in the initial stage of developing child advocacy since it not only allows a variety of professional skills to be employed but also, since the goals identified are usually quite specific, allows evaluation of the success of the separate components of each attempt at intervention.

Stage I: Crisis Intervention

It is proposed that initiation of a child advocacy process begin with children who have already been identified as deviant by the four major community-wide systems with responsibility for children's socialization, including re-socialization for children identified as socially maladjusted, emotionally disturbed, underachievers, delinquent, etc. The systems are education, mental health, juvenile corrections and social welfare. Each has its own way of defining and responding to deviance in children but all are concerned with those who are not "making it" by failing to meet important expectations regarding competence and appropriateness of behavior.

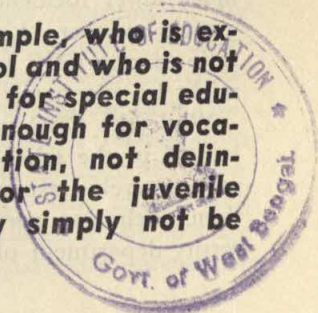
More specifically, the objectives of the crisis intervention stage are: (1) to identify children who are already in trouble; (2) to coordinate and follow up on existing services that are, or might be, provided to

such children; (3) to provide additional services that are needed but not currently available on a limited and temporary basis; (4) to evaluate the effectiveness of current services in order to plan for change in the delivery systems; and (5) to establish a child advocacy board. Briefly, the rationale for the initial stage is to increase the flow of information among the four systems involved in order to make maximum use of whatever resources are already there for children seen as needing help. There would be no new resources introduced in stage one except personnel to provide liaison between the agencies concerned and the families and children being served.

A serious problem exists in articulating the current patterns of service for children; there is much overlapping, time wasted in getting referrals to appropriate agencies, lack of information about available services, and children can be better served simply by making better use of programs already open to them. In the process of testing this hypothesis it is reasonable to suppose that real gaps in the array of services for children in a particular community will be revealed, such as short-term residential facilities or diagnostic resources for school learning problems, and that these shortcomings will become targets for implementation in stages two and three.

For professional staff in the crisis intervention stage the child development consultant (CDC) model seems most appropriate. This is a new role being developed

A child, for example, who is expelled from school and who is not retarded enough for special education, not old enough for vocational rehabilitation, not delinquent enough for the juvenile courts, etc. may simply not be served. . . .



in five experimental training programs supported by NIMH to train educators with a behavior science orientation to work with teachers and parents in identification and prevention of behavior and learning problems, consultation on behavior management and educational programming, and coordination of various treatment resources in the community. The CDC usually has a background of experience and training in elementary education with additional graduate training in psychology and special education. The CDC training is not all-encompassing and the effective implementation of the role requires carefully planned consultation with specialists from a variety of disciplines concerned with children. Such persons are now available, although not in large numbers, and could be recruited almost immediately as staff for the crisis intervention stage to initiate a child advocacy demonstration. It is anticipated that the number of CDCs assigned to a school will vary as a function of the size of the school and the characteristics of children served by it. As a maximum-minimum estimate, it is possible that a black, inner-city school with a high density of problems and scarcity of services might require a ratio of one CDC to every 100 students enrolled. That is an educated guess based on an incidence level of 15 to 20% and the supposition that each CDC may have to provide substantial direct service in the absence of adequate treatment facilities. In a suburban school with a much lower incidence of problems and a greater number of treatment resources a ratio of one CDC to 500 school children might be adequate.

While the CDC staff may be physically located in the school, they should be administratively responsible to the consortium, including agencies such as a university department of special education, a

Current efforts to evaluate action programs are clumsy and imprecise, usually offering uncertain assessment of experimental programs after they have run their course.

university division of child psychiatry, the city public school system, the mental health center, the county juvenile court, the county welfare department and parents and citizen groups, with a representative of each participating unit as a policy making child advocacy board. The CDC staff will be responsible to the child advocacy board for the coordinating and service functions and for calling attention to deficiencies in current service arrangements. During this stage the board will be primarily in an evaluative stance with regard to the adequacy of services for children rather than moving immediately to change or augment systems. It is to be expected, though, that individual members of the board may return to colleagues in their agency with suggestions that result in modification of service delivery even during the initial stage.

Training and research will be a major continuing concern of the child advocacy board. Even though trained CDCs are available, it is likely that experience will suggest different emphases in the training of new CDCs or the recruitment of different kinds of persons into the role.

Evaluation, in part, will be informal, based on CDC staff reports of problems encountered in working with individual children. Evaluation will also require the development of formal research procedures to document the impact, or lack of it, on children's lives of efforts to provide experiences that reduce deviance and enhance growth. Current efforts to evaluate action programs are clumsy and imprecise, usually offering uncertain assessment of experi-

mental programs after they have run their course. New techniques will need to be developed to indicate not only what a program has done but what it is now doing, to provide constructive feedback for greater effectiveness while it is still under way.

Perhaps the most demanding task for the CDC staff and the child advocacy board during the crisis intervention stage is to plan for stage two: reaching out into the community to develop early identification and prevention programs. Reasoned judgments must be made regarding types of children and types of behavior settings that are related to high risk of deviant behavior in the particular community served. We have, and should use, general leads from prior research about both personal and environmental factors that contribute to deviance but the focus of stage one is on problematic relationships in one specific community and the pattern of organized programs required to solve those particular problems.

Stage II: Outreach into the Community

Stage one is concerned with effective mobilization of treatment resources for children already identified as deviant by the four principal child-socializing institutions in the community. Stage two maintains that concern but broadens its focus to include other institutional forms that address themselves more to normal child development to begin the identification of high-risk children, including pre-schoolers, or high-risk behavior settings prior to the onset of serious deviance, and to begin preventive programs designed to reduce deviance and enhance normal development. The systems to be included in stage two

can be less clearly specified than in stage one. Certainly families must be a central component in any effective effort to reduce the incidence of deviant behavior in children. The designation of other potent components must await assessment of the social dynamics of a particular neighborhood, but one would expect to find included church groups, pre-schools, day care centers, recreation programs, organized athletic programs, boys' clubs, etc., and less formal, but regular, behavior settings such as street gangs or neighborhood play groups. The potential population for preventive programs in the outreach stage is all the children residing in the area served by the elementary school, whether they are attending the school or not.

The specific objectives of the outreach stage, in addition to continuing the crisis intervention programs, are: (1) to develop systematic "early warning" techniques for children who are not yet exhibiting serious deviance but who seem likely to do so based on the history of similar children or children in similar circumstances; (2) to initiate growth-producing programs for children so identified, such as special pre-school experiences or training for their parents; (3) to initiate treatment programs identified as missing in stage one; and (4) to continue to monitor and evaluate effectiveness of the various service components. Generally, the outreach stage is still focused on individual children, although in moving into preventive programming one would anticipate modest changes in, and additions to, the system of services to children such as tutoring programs in the school, weekend recreation programs, etc. Perhaps the most radical innovation in stage two is the aspiration of a single organization to make, and maintain, sufficient contact with all children within a designated area to be able to make a judgment that a particular preventive

program is needed and to act on that judgment.

The staff needed to implement the objectives of the outreach stage are clearly of a different magnitude than for crisis intervention, where coordination and evaluation of existing services is all that is required. At least two new kinds of workers will need to be added. For convenience, one will be called a "home visitor", the other an "educational technician". The role of home visitor is critical in developing techniques for early identification, monitoring the progress of children's development, on-the-spot consultation to parents

Without anticipating specific issues, it is safe to assume that vested interests and unconscious biases exist in all organizational arrangements serving children and will make change difficult.

and other concerned adults in the community and feedback to the child advocacy board regarding effects of preventive efforts. He will work under the supervision of the CDC and, like the CDC, will have available consultation from specialists in mental health, education, social welfare, and corrections. The case load and responsibilities for home visitors will vary with the population served, and the resources already available, such as public health nurses or day care centers, but a necessary condition for their effective functioning is that each home visitor have a clearly designated group of families for whom he feels responsible and acts as advocate in securing services, both remedial and preventive.

While the home visitor is a generalist, concerned with the welfare of a number of families, the educational technician is a specialist in the application of a particular method of intervention that might be use-

ful at times for any of the children served by the advocacy system. "Educational" does not necessarily imply that he works only in the school although it would be convenient for the educational technician to have an area in the school set aside as a resource room in which much of his work with individual children might be done. The particular roles and training required for the educational specialists must await assessment of problems, both of individual children and of behavior settings, during stage one, but it is reasonable to suppose that perceptual training, remedial reading, remedial arithmetic, behavior management, functional analysis of social behavior, group dynamics, and parent education would be among the skills that should be represented in a group of educational technicians. Like the home visitors, the educational technicians will be supervised by CDC staff with consultation from a variety of specialists.

The CDC is an educator with a behavior science orientation. The home visitor and educational technician need not be so extensively, or expensively, trained. The principal requirement of the home visitor is that he be able to establish and maintain rapport with the families assigned him. This may be as much a matter of personal qualities, including socioeconomic background and race, as training, which suggests that home visitors should be recruited from the neighborhood in which they will serve. Initial training might be fairly brief and continued through supervision by the CDC. The educational technician needs to be knowledgeable in depth in a single, or a few, techniques of intervention. An intensive workshop experience might be sufficient in developing the level of skill required in an otherwise untrained person, or the initial assignments might be given to undergraduate students in education or psychology, for practicum credit, in order

to assess the demands of the educational technician roles. With both the home visitor and the educational technician roles, thoughtful consideration needs to be given to the possibility of developing the "career ladder" progression of an income-producing job that is related to a degree or certificate-producing educational program for persons who might not otherwise move through academic requirements into technical or professional positions.

Research during the outreach stage will continue to focus on effectiveness of programs but will be expanded to include some longitudinal studies of systems rather than individual children. Indicators such as number of school failures and exclusions, commitments to juvenile court, etc., will provide systematic feedback to the child advocacy board to help in planning stage three.

Stage III: The Child Advocacy System

The ultimate form of the child advocacy system cannot be described in detail since its specific components will emerge from evaluation and planning during the two earlier stages. It does seem likely that to the emphasis on treatment and prevention of behavior and learning problems will be added a concern with the structure of systems that serve children. The crisis inter-

vention stage is designed to help children who need treatment get whatever is available. The outreach stage is designed to increase the effectiveness of existing services and begin preventive programs with target groups such as parents or pre-schoolers. These two stages are person oriented, directed toward individuals or groups of children who have, or are likely to develop, problems. Stage three will examine the social systems serving children and ask, "How can these systems be modified, restructured or augmented in order to reduce the need for treatment and prevention programs?" At this time we may anticipate three general objectives for fully-developed child advocacy: (1) to identify characteristics of child-serving systems that contribute to deviant behavior; (2) to initiate change in systems so identified; and (3) to evaluate the effects of that change on children's behavior. The task will be a complex one and assumes distinctly political overtones as one moves into the arena of institutional change. Without anticipating specific issues, it is safe to assume that vested interests and unconscious biases exist in all organizational arrangements serving children and will make change difficult. The gradual movement from existing programs to child advocacy will be a test of the hypothesis that given sufficient information and concern we can make our institutional forms responsive to children's needs.

Ethical Considerations in the "Involuntary Commitment" of Children and in Psychological Testing as a Part of Legal Procedures

Many of the precepts that guide mental health professionals in working with children are questioned. The ethical problems that would bother one when working with adults are examined as they relate to children. The author urges all those whose decisions can influence the course of the child's life to be aware of their responsibilities.

Explicit ethical standards usually evolve within a profession from the questioning of comfortable assumptions. This paper will consider some of the assumptions made in committing a child for inpatient care, a decision that requires explicit ethical safeguards and the clear delineation of ethical procedures because most—but not all—children are "involuntary commitments." Child commitments rarely meet the rule-of-thumb legal standard for involuntary commitment of adults, namely that the patient present a clear hazard to himself or to the community.

The legal profession has already defined some standards—work which is contained in the majority opinion prepared by Justice Fortas in the Gault decision, a review of a court case which could have resulted in the institutionalization of a fourteen-year-old

boy for six years for making an obscene phone call. Some of the parallels between juvenile justice and decisions for therapeutic hospitalization are striking. Fortas describes the concepts underlying the relatively recent establishment of the juvenile court system: "The idea of 'crime' and 'punishment' was to be abandoned. The child was to be 'treated' and 'rehabilitated' and the procedures from apprehension through institutionalization were to be 'clinical' rather than punitive." The state was proceeding as "parens patriae"—a phrase which Fortas notes was "a great help to those who sought to rationalize the exclusion of juveniles from the constitutional scheme." The early conception of the juvenile court proceeding was one in which "a fatherly judge touched the heart and conscience of the erring youth by talking over his problems . . ." Fortas acknowledges the benevolent motives of most juvenile judges and grants their good will and compassion,

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but concludes that the unbridled discretion lodged in juvenile courts is a poor substitute for due process safeguards. (When one is reminded that the heaviest sentence possible for an adult who makes an obscene phone call is two months in jail, the Gault boy seems indeed to have been treated to an excess of "benevolence".)

Fortas takes issue with the rationale that friendly and informal courtroom procedures provide a natural beginning to rehabilitative therapeutic process. He cites evidence that "the child feels enticed and deceived when friendly informal procedures lead to a disposition he regards as punitive and that far from being open to therapeutic change, he feels instead a despairing helplessness in the face of unchallengeable authority . . ." The opinion continues: "The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is committed is called an Industrial School. His world becomes 'a bulding with white-washed walls, regimented routine and institutional hours . . .' Instead of mother and father, sisters and brothers, friends and classmates, his world is peopled by guards, custodians, state employees, and delinquents confined with him for anything from waywardness to rape and homicide."

When we turn from Fortas's exposition of his profession's "comfortable assumptions" about rehabilitation to a consideration of our own profession's toward hospitalization, many parallels are apparent: benevolent motives, undeniable compassion for parent and child, a fairly detailed investigation of home conditions and a serene sense that institutionalization will implement therapeutic change. The purpose in considering the existence of attitude bias and blindspots about negative aspects of

hospitalization is to open the possibility that hospital admission committees might need some "due process" safeguards of their own in child commitment procedures. Like juvenile authorities, when we consider commitment of a child we are usually acting against his wishes but "for his own good". Parents are likely to vary greatly in their readiness to consider hospitalization—from great willingness resulting from weary exasperation or exhaustion to extreme reluctance with only a minimal willingness to accept the evaluation of the "experts".

Strangely enough, it is too often only the child who keeps in mind the fact that he will be living in a large institution and be cared for by strangers; that he will be removed from parents, brothers, sisters, pets and the rest of his own personal familiar life space. Since in many cases the professionals who make such decisions work daily in such institutions and become familiar with them and their therapeutic intent and effect, they may forget their frightening and relatively impersonal aspects. In short, professionals making decisions to hospitalize

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are highly likely to hold comfortable assumptions about the benevolent aspects of their own clinical settings.

It should be remembered that all of us who work in therapeutic relationships with children are likely to share another comfortable prejudice—unconsciously and consciously, i.e., that we can be much better parents to a disturbed child than his own

parents could be. This is, of course, the common rescue fantasy which is likely to comprise a considerable segment of the career motivation of all who work with children no matter what the discipline. We ought to be alert to the possibility that it

pitalizing their child needs a representative of its own, someone who can systematically and knowledgeably review the case and explore treatment alternatives—as the legal profession now provides counsel for the family, and in some cases for the child

"... unbridled discretion lodged in juvenile courts is a poor substitute for due process safeguards."

might lead to a tendency to underestimate the traumatic impact of separation from home; or the hazard it presents to a child whose object relatedness may already be weak and diffuse.

Professionals making a decision to hospitalize are often acting on the recommendation of a staff member who has conducted a diagnostic evaluation. He has already made his assessments about the need for removal from a pathogenic home. The tendency to rubberstamp his assessment is strongly reinforced by the prejudicial attitudes discussed above. Too often the only points still open to consideration are considerations about "bed space", training needs or the characteristics of the group already residing in the ward or the cottages. The question about the rightness of this disposition for this child at this time may be too easily obscured or delegated to the intake worker.

Perhaps ethically we ought to force ourselves in such circumstances to make provision in our procedures both to take precautions against our prejudices and to consider the preferences of the child and his parents, not only their needs. We too often set ourselves to "handle" parental resistance to the recommendation to hospitalize and must avoid a tendency to resort to techniques which verge on psychological blackmail in our efforts to do this. The family confronted with a recommendation for hos-

against his parents, instead of relying on the benevolence of the juvenile officer. As with court procedures, such an alternative is usually available to wealthy families and frequently utilized by them. It is middle and lower class families who are dependent on institutional opinion alone.

To return to the Gault decision, Fortas notes that the court official representing the child's interests was also the probation officer and superintendent of the detention home, and he concludes that he cannot act as counsel for the child. "His role in the adjudicatory procedure, by statute and in fact is as arresting officer and witness against the child. Nor can the judge represent the child." He needs, Fortas concludes, counsel of his own. Is it forcing the comparison to suggest that psychiatric personnel requesting inpatient hospitalization for a given child might be influenced in their decision by their other roles and functions in the hospital? Furthermore might they not be impeded in their future therapeutic effectiveness with the child by their role in the commitment procedures?

If the juvenile needs the assistance of counsel "to cope with problems of law, to make skilled inquiry into the facts, to ascertain whether he has a defense and to prepare and submit it," perhaps the prospective inpatient child and his parents need an expert to consider and perhaps to defend the alternatives they might prefer. Those

of us who do our clinical work in residential settings would have difficulty in extricating ourselves emotionally and intellectually from our convictions about residential treatment in order to provide an objective consideration of alternative treatment plans. Community mental health centers, on the other hand, seem ideally qualified to serve this function. Their inclination to keep the child in his home if at all possible would provide a "counter-prejudice" to any tendency to consider hospitalization too casually. Residential treatment centers are few and far between and tend to draw referrals from a large geographic area. Community mental health centers, on the other hand, have much more complete knowledge of the community resources that might be mobilized for a given problem. They are, in summary, natural "defense counsels" who could knowledgeably review and present acceptable, or preferable, alternatives to hospitalization and do much to make up for the present lack of procedural safeguards in child commitment procedures.

The need for due process safeguards is also evident in the current trend toward the use of psychological testing to make life decisions in court cases involving children. A commonly occurring situation is one in

This seems a shocking invasion of privacy and one that, again, is usually justified as being in the child's best interests.

which a lower-class family is charged with child neglect. The case comes to court; the children are made wards of the court and a psychiatric opinion is sought about the degree of psychological damage done so that a proper disposition—foster home, psychiatric setting—can be made. Into the hospital or clinic comes the "ward of the court", usually accompanied by his

"worker" whom he met for the first time a few weeks before under distressing circumstances. He has some sense that his mother, or his parents, are in trouble with the police. He is living in a Child Shelter and has probably been hauled from one forbidding building for a hearing to another for whatever purpose. Now he has been taken, to a hospital perhaps, to confront still another strange adult. Most such children clearly and openly express preference for being "neglected" at home to their current situation.

The child cannot plead the Fifth Amendment and what he unwittingly reveals about himself will be used when the court is trying to decide what to do with him. This seems a shocking invasion of privacy and one that, again, is usually justified as being in the child's best interests. The terribly important question is: "How can we be so sure?" There is nothing in our own experience or in our tools that would qualify us to judge the quality of his home or the pathology of its effect on him. Most psychologists have a limited experience with interpretation of the test performance of working class children—testing is an expensive, lengthy procedure. Since the examiner is likely to be a product of the middle class, he cannot draw on a pool of common experience to implement empathic understanding. If the psychologist has a bias toward middle-class mores, his tests also have a very important bias; they are much more efficient in revealing pathology than they are in revealing compensatory or adaptive reactions to pathology—they reveal the viruses but not the immunological response.*

* It can be argued that all test biases are really psychologist bias—our instruments have been developed according to our own needs and preferences which has resulted in a heavy preponderance of syndrome research to the neglect of normative research.

The psychodiagnostician, then, examines his limited evidence with his limited experience and finds from the testing that the child feels very deprived, feels that he is underprotected and much on his own in a hostile world, and, further, that the child has a reservoir of anti-social, anti-familial hostility and aggression. The psychodiagnostician may well prognosticate a sociopathic character adjustment if the child is not removed from the home—a recommendation received with varying degrees of seriousness by judges who are more aware than we psychologists tend to be of the biases of our instruments. It just could be that all lower class children would be seen in testing as feeling very deprived, underprotected and much on their own in a hostile world.¹ The limitations of the tests and the examiner are not so much a problem when the tests are used only to investigate problem areas, typical defensive strategies and to help focus treatment plans. However, psychological testing should never be used in isolation to determine if psychotherapy or hospitalization is indicated for a given case. The bias of the tests can be corrected by the psychologists' understanding of their (and his) limitations and if they are used in conjunction with many other

psychologist has a clear choice. He can make himself a specialist in testing lower-class children so that he can build a frame of reference, a set of internal norms for judging the degree of aberrance of his child subject's test performance. (This is mainly a problem with poor children. Neglect and abuse in more prosperous families comes more rarely and indirectly to the court's attention. Middle and upper middle class delinquents are more often assigned probationary status and are able to secure psychiatric help on a private basis.) This would allow him to correct for his own middle-class bias and for the test's bias toward revealing pathology. In addition to this, he can refuse to allow himself to testify in disposition hearings as an "expert tester" only. His opinion should be allowed to include interpretation of the test results in conjunction with the interrelation of test material with the current crisis in the child's life and the defensive-expressive style typical of his socio-cultural background. For example, if a child is seen in testing as very frightened, severely depressed, withdrawn and nearly mute, this should not be presented as data about the parent-child relationship without also considering the fact that he has spent two weeks in a child shel-

Younger or less canny and experienced children reveal more than they would wish to.

kinds of information about a child. However, the court rarely uses a psychologist as an interpreter of a wide variety of data—he is the "expert tester", even though his expertise in this field in most cases is based solely on his experience with a pathological population; that is, in clinics and hospitals where his test subjects are already defined as patients by themselves, their families and by other staff members. It seems that the

ter and hasn't seen family, friends or anything reassuringly familiar for that period of time. In evaluating the uncommunicativeness, the psychologist might school himself in some of the sociologists' findings about poor families—that the response of any child or adult from his socio-cultural milieu includes retreat to frightened silence in any contact with "the law."

If the psychologist has not filled the defi-

cit in his background by extensive study of typical projective test performance of working-class or minority groups, he should confine his function to post-hearing testing. When the decision has been made to place a child in a foster home or a psychiatric setting, he can ethically use his tests in the traditional way—to delineate problem areas and suggest effective means for focusing treatment approaches on them. It is commonly suggested that psychological testing provides important information in making disposition decisions. I am suggesting that until we can be sure it is accurate information, free of socio-cultural bias and test bias, it is better withheld.

The psychodiagnostician should consider carefully his frequently phrased reassurance to his child-subject—"We are going to do some tests that will help us to make the best plan for you." Your "best plan" may be a very long psychological distance from his "best plan." We have all no doubt had experience with the child who senses just exactly that. If he is older and has had a longer association with public agencies, he can have a shrewd sense of what we are about. His TAT stories and other less ambiguous projective test responses indicate that his family never does anything but pray and go on picnics. Younger or less canny and experienced children reveal more than

they would wish to. Perhaps all such children ought to be warned about the uses to be made of testing in court. However, warning ought to in no degree diminish the psychologist's ethical responsibility when he uses his tests to see what the child would not willingly show him, to report what would be confidential material if it were willingly and consciously reported by an adult in treatment, to an end which the child would resist strongly if he didn't have an accurate perception of his weakness and helplessness in this situation.

The mental health professions are becoming more and more responsive to suggestions that they define their social responsibilities more broadly. It is important, however, that we do not develop social conscience at the expense of scientific or professional conscience—that we keep clearly in view the limitations of our methods, our training and our life experiences and limit accordingly both our claims to expertise and the responsibilities we undertake.

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David Elkind, Ph.D.

Exploitation and the Generational Conflict

This paper elaborates the thesis that exploitation (breaking of implicit contracts) by parents and adults is often the issue on which the conflict between young people and adults is centered. The first section of the paper presents a general scheme of development of parent-child relations in terms of a series of implicit contracts and explicit agreements and bargains. The next section describes work with middle class delinquents which suggests that developmental exploitation (breaches of the contract by demands for age inappropriate behaviors) and egocentric exploitation (breaches of the contract by demands for excessive amounts of age appropriate behavior or uncompensated behaviors) are related to two phenomenologically different forms of delinquent behavior. In the third section of the paper it is suggested that some forms of exploitation of youth are institutionalized and that changes in the nature of institutionalized exploitation can help to explain, in part at least, the character of today's youth revolt.

The generational conflict between parents and their adolescent offspring is a big problem and one which can be studied from the standpoint of many different disciplines including anthropology, sociology, psychiatry and social psychology. In the present paper, however, I propose to deal with the generational conflict from the perspective of developmental psychology, that is to say, from the position which sees parent-child interaction as evolving in a

sequence of stages that is related both to the age of the child and to the maturity of the parents. From this perspective, the generational conflict can be viewed as a stage in the process of self differentiation whereby youth seeks to further emancipate itself from adult authority by attacking that authority directly.

A conflict, however, never takes place in the abstract and always occurs in the context of particular issues. In this paper I want to suggest that a major source of issues for the generational conflict lies in the real or imagined violations of implicit contractual arrangements between parents

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and their children. When parents violate such a contract their offspring usually interpret this breach as stemming from selfish motives on the part of the adults and hence experience violations as exploitation. It is this feeling of exploitation, or so it appears to me, which is one of the prime foci of the generational conflict whether it manifests itself individually in parent child quarrels and more dramatically in delinquent acting out or collectively in such movements as the student revolt.

To make this proposition concrete, I propose, in the first section of this paper to describe the development of parent child contracts in general and the major clauses of those contracts in particular. Then, in the following sections, I want to try and show how violations of these contracts can be related to two different manifestations of the generational conflict, namely, middle class delinquency and the student revolt. It is perhaps well to emphasize at this point that I am not arguing that the violation of contractual agreements is necessary and sufficient to explain the generational conflict. Far from it. What I am saying is that in Western society such violations have provided youth with at least some of the issues upon which to base their struggle for independence.

The Development of Parent-Child Interactions

One way in which the development of parent-child relations can be viewed is from the standpoint of the kinds of give and take arrangements that are explicitly or implicitly operative at all levels of development. At least three types of arrangements can be distinguished; the bargain, the agreement and the contract. Each of these types of arrangement needs to be dealt with in a little more detail.

The simplest and most temporary parent-child arrangement is the bargain. In the bargaining arrangement, the parent offers the child some reward or withholds some punishment in return for a particular behavior on the part of the child. To illustrate, when the parent offers the child a piece of candy if he will go to bed, this constitutes a bargain, a sort of one shot arrangement. A child, at least a middle-class child, soon learns to initiate his own bargains at a fairly early age. A child initiated bargain is illustrated by the following remark, "I'll get undressed and brush my teeth if I can stay up and watch *The Flying Nun*." Bargains change in their content as the child grows older, but continue to be viable means of socialization and inter-familial interaction.

A somewhat more complex, and more long lasting, arrangement is the agreement. In the agreement arrangement, the parents and child agree to abide by certain rules over an indefinite period of time. Agreements with young children often involve the threat of punishment, "If you hit your little brother again you will have to go to your room and miss the cartoons." which can be translated as, "If you agree to leave your little brother alone we agree to let you watch the cartoons." Like bargains, agreements change in their content as the child grows older but are present at all age stages of parent child interaction. In addition, whereas bargains appear to predominate at the pre-school levels, thereafter, agreements appear to become increasingly more prominent.

The most complex and least explicit parent child arrangement is the contract. A parent-child contract consists in the unspoken demands made by parents and child upon one another and which determine their mutual expectations. It is the sequence of parent-child contracts which

Because contracts are mostly implicit and are seldom verbalized directly, their existence often comes to the surface only in the breach.

most clearly reveals the developmental nature of parent child relations. Because contracts are mostly implicit and are seldom verbalized directly, their existence often comes to the surface only in the breach. The mother, for example, who says, "Look how they treat me after I worked and slaved for them," reveals her belief in an implicit contract as does the remark of an adolescent, "No matter how much I do around the house, it is never enough."

The contracts written during the major periods of growth; infancy, pre-school, childhood proper and adolescence, all have particular contents characteristic of that epoch. In addition, the contracts at whatever age level also appear to have at least three invariant clauses—compensatory demands between parents and child. These clauses are; the responsibility-freedom clause, the achievement-support clause and the loyalty-commitment clause. In the following paragraphs the content of these clauses at different age levels will be briefly described.

During each of the four major growth periods, the parents demand that the child accept particular responsibilities while the child contracts for complementary freedoms. Parents generally require very little in the way of responsibility of an infant and the infant, in turn, asks for little in the way of freedom. During the pre-school period, however, parents begin to demand that the child take responsibility for feeding and dressing himself, for bowel and bladder control and to a certain degree for emotional behavior. Children on their side, ask for some of the freedoms

made possible by their new mobility and motor control. They demand free access to the various rooms of the house, for crossing the street, and to handle tools and mechanical devices. In childhood, the responsibilities required of children become even more diverse and they are asked to look after their clothing, their rooms and their younger siblings. Children in their turn, demand new freedoms in the way of staying away from home for longer periods and for going further away from home. Again in adolescence, the contract is once more rewritten as parents request that young people take responsibility in the areas of sex, money and cars and as the teenager asks for new freedoms in the way of late hours, dress and friendships.

A similar developmental course is taken with respect to achievement and support. Parents demand little of the infant in the way of achievement other than that he walk and talk at the usual ages. The infant demands some emotional support for these achievements but such skills are largely self reinforcing. During the pre-school period, however, parents begin to make demands for achievement in the way of bowel and bladder control, linguistic prowess and social behavior. For his part, the child asks that the parent praise his accomplishments and devote time to supervising and instructing him. As the child enters school, parental demands for achievement come to center upon the three major areas of academic performance, athletic skill, and social popularity. In return children make complementary demands for material, intellectual and emotional support for their activities. During adolescence, parents intensify their demands in these areas and young people correspondingly escalate their requests for material, emotional and intellectual support. Parents of adolescents are sometimes fooled, by the prominent mone-

tary demands of this age group, into believing that their offspring are no longer interested in the more psychological forms of support. This is not in fact the case and psychological support from parents is perhaps more necessary during adolescence than at any other time.

Finally, in the area of loyalty and commitment, a developmental progression is equally discernible. Parents usually demand little from the infant in the way of loyalty other than that he respond to them positively and with affection. Likewise, the infant appears only to request that the parents be committed to their care taking function. As the child grows older the loyalty commitment clause begins to shift its focus. During the pre-school period parents demand that the child maintain his loyalty and affection for them in the face of his exposure to new adults such as nursery school teachers and baby sitters. The child, in turn, asks that parents maintain their commitment to him as new chil-

In adolescence . . . parents ask loyalty to their beliefs and values while the young person demands that parents be committed to the beliefs and values which they espouse.

dren are born into the family and as he makes new and greater demands upon their time and energies. Once the child enters school, parents generally require that loyalties to his family supersede his loyalties to the teacher and peer group. On his part, the child demands that parents give evidence of their commitment to him primarily in terms of the amount of time and interest they devote to his endeavors. In adolescence, this loyalty commitment clause takes on a still another coloration as parents ask loyalty to their beliefs and values

while the young person demands that parents be committed to the beliefs and values which they espouse.

This all too brief sketch of the development of parent-child contracts may, nonetheless, suffice to illustrate both the age related character of these contracts and the pervasiveness of the clauses regarding responsibility-freedom, achievement-support and loyalty and commitment. Obviously this is a normative schema which holds primarily for intact, middle class families in America. While I believe that parent-child contracts are written in families at all socioeconomic levels and in all cultures, the nature of the contracts and the invariant clauses they entail will necessarily vary in importance, if not in kind, for boys and girls and for different socioeconomic and cultural groups.

Contracts and Delinquency

As I suggested earlier, our knowledge of parent-child contracts often comes from those cases in which the arrangements have gone awry rather than from the cases in which the contracts have been honored. As so often happens, the exceptions illuminate the rule. My own awareness of the importance of parent child contracts come from my work with middle class delinquents.² In that paper, I discussed the role of contractual violations in the production of delinquent behavior. My aim here is not to recapitulate that discussion but rather to expand it and to differentiate between two different ways in which parents can exploit children and to describe the different patterns of delinquent behavior which seem to result.

When a parent ignores the contractual obligations imposed by the child's age and demands behaviors which are either above

or below the child's actual level of maturity we can speak of developmental exploitation. Parents, for example, who overprotect their children have in effect not only demanded inappropriate behaviors but have also offered inappropriate freedoms, supports and commitments. Contrariwise, parents who provide freedoms, support and commitments which are too advanced for the child's level of responsibility, achievement and loyalty have also failed to meet their contractual obligations and engaged in developmental exploitation. In such cases the parents are often too rigid or too anxious to flexibly adapt their behavior and expectations to the child's constantly changing powers and abilities. It is, therefore, the parents' inability to cope with their child's growth that lies behind their attempts to unduly impede or accelerate his development.

Exploitation, however, can also occur when the reciprocal demands of parent and child are appropriate to the child's age level. In such cases the exploitation results from a quantitative rather than qualitative violation of the contract and which might be called egocentric exploitation. We encounter egocentric exploitation when the responsibilities, achievements and loyalties required of children are appropriate for their age level but are requested in excess of what is reasonable or are demanded when the parent fails to provide the complementary freedoms, supports and commitments. Such exploitation is egocentric because in these cases the parent sees his own needs and problems as more important than those of his children.

In my work with middle class delinquents I have observed what appears to be a reasonably close relationship between developmental and egocentric exploitation and two phenomenologically different varieties of delinquent behavior. Among mid-

dle class adolescents who get into trouble with the law are those who are clearly emotionally disturbed and have internalized conflicts of long standing. On a purely descriptive level, these youngsters usually engage in delinquent behavior alone or with someone appreciably older or younger than they are. The act itself is frequently symbolic and bizarre (shooting up a school, molesting young girls and so on). Young people of this kind tend to be authority rather than peer oriented in their moral and social judgment and are, moreover, generally immature in their interests and choice of companions. In cases of this sort I have frequently found a history of developmental exploitation on the part of the parents wherein either the mother or father, and not infrequently both, treat the child as younger or older than his true level of maturity.

In contrast to such neurotic youngsters in whom unconscious feelings of exploitation sometimes find expression in illegal acts, is a much larger group of young people in whom the feeling of exploitation is quite conscious and clearly tied to parental behavior. Phenomenologically speaking, such adolescents are quite easy to distinguish from the neurotic youths. First of all, they usually get into trouble as a member of a group and seldom do so while acting alone. Their delinquent actions are, moreover, of the more or less conventional variety in the sense that they steal cars, become truant, act out sexually, or run away from home. They are, in addition, peer rather than authority oriented which is to say that they will not, for example, tell on friends whom they see engage in delinquent actions, and respect peer ethics and standards rather than abstract adult value systems. Such young people, generally have interests and friends appropriate to their age level. Again, in many of the cases of this sort

which I have seen, the pattern of parental exploitation has been of the egocentric rather than of the growth variety. Parents of "socialized" adolescents are found either to be demanding behavior in excess of what is reasonable or, on the contrary, to be remiss in fulfilling their part of the parent-child contract.

In summary, then, clinical experience suggests that the way in which parents exploit children, either developmentally (by demanding behaviors inappropriate to the child's age level) or egocentrically (by demanding excessive or uncompensated amounts of age appropriate behaviors) is related to two different varieties of delinquent acting out behavior. This is, to be sure, a relatively gross observation and we need to find ways of measuring these different patterns of parental exploitation and of relating them systematically to our diagnostic categories of adolescents who become delinquent.

Exploitation and the Youth Revolt

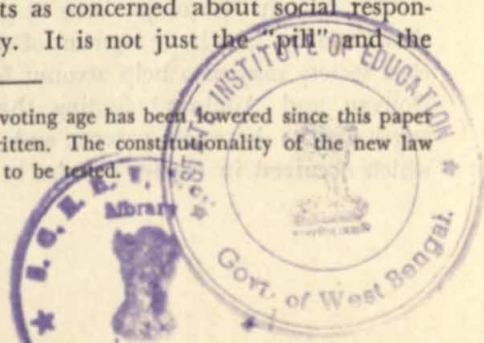
In the preceding section it was argued that parental exploitation on the part of individual parents could lead to delinquent behavior by their offspring. Exploitation is, however, not always an individual matter and some forms of exploitation are widespread and are fostered by the socioeconomic conditions prevalent at the time. There are, in other words, likely to be institutionalized forms of parental exploitation in the sense that most parents will engage in it, not because of individual quirks of personality but rather because such exploitation is considered socially appropriate and is socially sanctioned.

Before the passage of child labor laws, for example, developmental exploitation was socially sanctioned and children were expected to work as hard and for as long

hours as were adults. In recent years, institutionalized developmental exploitation has moved to the other extreme and society today tries to keep youth out of the labor market long after it is capable of productive work. Egocentric forms of exploitation have also become institutionalized at certain periods in history and such institutionalization has frequently emphasized one or another of the clauses of the parent child contract. In earlier decades of this century, for example, parents demanded considerable responsibility on the part of their children who were expected to help on the farm or in the family business or to be wage earners who contributed to the family income. Young people were not, however, granted the corresponding freedoms and had to fight parental prohibitions against living alone or befriending whomever they wished. This imbalance in the responsibility-freedom clause is still very much an issue in the generational conflict in the smaller towns of the Midwest and South today. A carryover of this form of institutionalized exploitation is the fact that the draft age is 18 while the voting age is 21*. It is a nice example of how society can demand responsibility without providing the corresponding reciprocal freedom.

In the urban areas of the Northeast and Far West, however, the focus of institutionalized egocentric exploitation no longer centers upon the issue of freedom-responsibility. Freedom for adolescents in the suburbs and cities is hardly a sore point today when owning cars, keeping late hours and taking overnight trips is generally accepted as part of the youth culture. Nor are parents as concerned about social responsibility. It is not just the "pill" and the

* The voting age has been lowered since this paper was written. The constitutionality of the new law is still to be tested.



knowledgeability of modern young people in matters of sex and contraception, however, which has made responsibility less of an issue. Rather it is the general sophistication of youth today which is often greater than that of their parents and which often makes parents embarrassed to impose restrictions.

If responsibility and freedom are no longer a point of contention between par-

Behind the demand for student power, and the turning on and tuning out, lies youth's resentment at an adult society that has been looking out for itself and which has forsaken youth's future for its own immediate good.

ents and adolescents the loyalty-commitment clause of their contract most certainly is. What young people feel today is that adult society has not lived up to its obligations to youth and consequently they feel no reciprocal need to be loyal to the values and beliefs of that society. Youth sees this lack of commitment all about it: in the form of a war fought more for pride than for justice and at the expense of youth; in the credibility gap; in the revelation of the extent of social and racial injustice; in the pollution of the air and waterways and in the disgrace of our cities. Behind the demand for student power, and the turning on and tuning out, lies youth's resentment at an adult society that has been looking out for itself and which has forsaken youth's future for its own immediate good.

This shift in the major issue of generational conflict in a large segment of middle class society may also help account for the Douvan and Adelson¹ finding that the angry battles between parents and youth which occurred in earlier decades is much

less prevalent today. This change in the overtness of the parental child conflict makes a certain kind of sense if we assume that in earlier decades freedom-responsibility was the issue whereas currently it is on the grounds of loyalty and commitment. When youth fights for additional freedoms, the goals are specific and concrete and both victory and defeat are clear cut. Not so when the issue is loyalty and commitment. Parental granting of freedoms is a relatively easy affair compared to an alteration of their commitment to youth. Young people know this. They are aware that demanding that their parents take a stand can never succeed and is a senseless battle.

It is in the context of this sense of futility in battling parents that I think many of the group youth revolts, which are both direct and indirect reactions to authority in general, must be understood.

To be sure, youths' charges against adults contain a certain amount of exaggeration and distortion. Youths' charge, for example, that adults are materialistic in their values lacks perspective. For the most part middle class youth of today have grown up in relative affluence and the concerns about getting a good job and making a good living which motivated their upward striving parents seem foreign and a little despicable to the children. Young people today take it for granted that they can get a good job and make a good living and cannot conceive of their parents' anxieties in this area. Likewise, youths' belief in the lack of adult commitment to future generations is probably not the whole truth. In many cases it is probably more true that values have undergone such rapid change in the last twenty years, as far as young people are concerned, that many parents don't really know where they stand on many moral and social issues. They cannot continue to abide by the values accord-

ing to which they were reared nor can they really accept the new value system. Youth mistakenly interprets this vacillation as a lack of concern with their welfare and translates a genuine "I don't know" into "I don't care." In fact, however, it is often because parents do care that they have tried to avoid imposing outdated demands upon their children.

In summary then, the issue which seems to stand at the forefront of today's institutionalized generational conflict centers around the loyalty-commitment clause of the youth society contract. Whereas youth has always been critical of adults for not really being committed to, or living according to, the values and beliefs they espouse, what is new today is youth's feeling that adult society has no real commitment to youth and to forthcoming generations. Hence youth will no longer trust adults to determine their future and want to take

part in the planning of their education and in the direction of government. As always youth has gone to the heart of the weakness in adult society. Since, however, the generational conflict is a growth process in which both youth and adults participate it can be a healthy force for change in the society at large as well as a mechanism of growth for youth. And, if adults feel harried and under attack by youth, they can take consolation in the fact that the current protagonists of the generational conflict will one day feel perhaps even more venomous barbs from the verbal onslaughts of their own offspring.

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Hospitalizing the Young: Is It For Their Own Good?

The authors question the advisability of hospitalization for children and adolescents, arguing that their admission for treatment may have long term deleterious effects on them. Among these are the stigma attached to hospitalization, the impact on self-concept, reduced opportunities for future self-determination and the possibility of diminished social competence. Juveniles should not be denied hospitalization for treatment when indicated, but this action should only be taken after careful deliberation of all the consequences.

Admission to inpatient status of children and adolescents has increased sharply in recent years. It has been estimated that resident patient populations are expected to decrease for the population 25 years and over, but increase by sizable amounts in the age groups under 15 years and 15-24 years. There were more than 5,000 children and adolescents under age 15 in state and county mental hospitals in 1963, and it is estimated this will increase to over 13,000 by 1973.⁷

Children and adolescents are admitted to state hospitals through a mutual selective process involving a sponsoring com-

munity agent and the hospital authorities. It is understandable that there is sometimes misapprehension and disagreement about some fundamental issue such as the purposes of child-adolescent units in state hospitals, mental health needs of children, the nature of childhood psychopathology, and what constitutes treatment or remediation. Differences of opinion about legitimate uses of state hospitals also exist. Some believe that using an adolescent ward as a detention facility is a lesser evil than housing a juvenile in a county jail. Temporary or short term hospitalization is considered appropriate to provide a respite for the family during a period of crisis until tensions diminish. There is also a question about the extent to which juveniles are admitted to a state hospital on the basis of a positive choice rather than by default.¹

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Hospitalizing the young

Miller and Kenney conducted a study of adolescents admitted over a period of three years to the inpatient service of a psychiatric hospital, with the focus on the relevance of psychiatric services. An examination of their population revealed they could divide their admissions into two broad groupings based on reasons for admission and psychiatric status. The larger group was referred for delinquent behaviors or as being at odds or in difficulty with the community. These adolescents were not seen as requiring or benefiting from psychiatric intervention, at least in an inpatient hospital setting. The non-delinquent group, whose admission to the hospital was judged as appropriate, were "referred on a markedly different basis, with specific descriptions of symptoms and usually without a sense of urgency on the part of the source."⁸ Increased admissions of adolescents were seen as stemming from a lack of understanding about what psychiatry could and could not do, unrealistic expectations of the community, and the failure to differentiate social from psychiatric problems.

It is not the view or intent of the authors of this paper that children and adolescents who should be hospitalized, and can benefit from hospitalization, be denied such care and treatment. However the position taken here is that the hospitalization of juveniles ought to be viewed as a momentous event, one with much potential for harm, and one not to be undertaken casually or lightly. Those with the authority to admit, should carefully consider the possible disadvantages and dangers of admitting juveniles to psychiatric hospitals, and weigh short term advantages against the possible lifelong consequences of hospitalization.

The chief dangers of hospitalization of children and adolescents are the development of a negative self-concept, reduced

social competence and coping skills outside the institution and, most importantly, falling victim to social stigma and its correlates of rejection and reduced opportunities for self-determination.

For more than a decade there have been attempts to carefully document social deterioration associated with hospitalization. The general thesis is that much of the deviant behavior of chronically institutionalized patients develops subsequent to hospitalization. While Gruenberg has pointed out that the development of what is called the social breakdown syndrome is first manifested prior to, and is a common justification for hospitalization, the progressive development of chronicity is independent of any particular mental disorder.⁴ The term 'institutional neuroses' is another concept that has been used to characterize the behavioral and mental changes that may result from institutional life.² The notion is that the very circumstance of institutional living, especially the quality of relationships among patients, and between

One has good reason to suspect that the term "voluntary admission" is an ironic semantic ploy since it is not likely that the juvenile is doing the volunteering.

patients and staff, leads to deterioration of social functioning which furnishes further reason to maintain a person in the hospital.

In a study of retardates, Cain and Levine compared the effects of a community with institutional school programs on trainable mentally retarded children.³ They found that children in the community improved while institutionalized children decreased in social competence. The quality and kinds of behavior that institutionalized children may develop are not in keeping

Rejection by society is frequently cited as the major negative side effect of hospitalization in a mental hospital.

with the modes of social skills and interactions required in community life. The extent that these concepts apply would, of course, be related to the length of hospitalization, and is probably not a danger for short periods of inpatient care.

Rejection by society is frequently cited as the major negative side effect of hospitalization in a mental institution. Kenefick has put it this way: "To call a person a 'delinquent' or a 'schizophrenic' is to set in motion usually a number of wheels and millstones which can as easily grind the patient as the 'disease' itself, even if the only person who 'knows' the diagnosis is a therapist. . . . More perniciously, in a larger context, it may involve social processes that have evolved to deal with 'impossible cases' . . . : and these, at best, then add to the original diagnostic terms of even more crushing social meaning, such as 'ex-con,' 'former patients,' and so on."⁸ In an opinion of the Supreme Court of Wisconsin concerning the rights of a juvenile on a finding of mental illness, the point was made that "Despite protestations to the contrary, the adjudication of delinquency carries with it a social stigma. This court can take a judicial notice that in common parlance 'juvenile delinquent' is a term of opprobrium, and is not society's accolade bestowed on the successfully rehabilitated."¹² Similarly, children and adolescents who were formerly mental patients may well become the objects of fear, distrust and suspicion.

The proposition that the very act of labeling a person sets them forth on a career of mental illness has been made by, among other sociologists, Scheff.¹¹ He

argues that the major consideration is not the quality of the behavior of the individual, but rather that the act of labeling a person mentally ill establishes the basis for the fulfillment of what the label implies.

The powerful role that a label plays, apart from particular behaviors of people, has also been pointed out by Phillips.⁹ He examined the effects of seeking help for problems of disturbed behavior "to determine the extent to which attitudes toward an individual exhibiting symptoms of mental illness are predicated on knowledge of the particular help source that the individual is consulting." He discovered that individuals described as exhibiting identical behaviors are increasingly rejected if they are described as utilizing no help, utilizing a clergyman, a physician, a psychiatrist, or a mental hospital.

. . . much of the deviant behavior of chronically institutionalized patients develops subsequent to hospitalization.

In a review of empirical research covering the past two decades of attitudes toward mental patients conducted under the auspices of the Wisconsin Association for Mental Health, Johannsen⁵ confirmed that being known as a mental patient carries a serious stigma. "The over-all view is grim; and the mental patient, usually defined as someone who has had some contact with a mental hospital, is treated with fear, distrust, and dislike. Only a little distinction is made between a neurotic and psychotic person." When the mental patient label is not imposed, society is likely to be tolerant of a great deal more aberrant behavior, often regarding symptoms as mere signs of eccentricity which confirms Scheff's view that the label mentally ill has greater impact than one's actual behaviors.

He also confirms that society is quite tolerant of deviant behavior as long as it is not labeled a manifestation of mental illness. And in support of Phillips' finding he reports "there is noticeably less stigma attached to having been in psychiatric treatment than having been in a state hospital."

Development of a negative self-concept has often been cited as a consequence of hospitalization which may lead to the fulfillment of the prophesy implied by the judgment. The child hospitalized and thereby labeled may easily persist in his belief that he is peculiar and different because he has been so regarded by an expert, a doctor, who ought to know. He takes upon himself the negative connotations attributed to the mentally ill: "When the patient is officially classed as a mental patient, perhaps by being placed in a mental hospital, perhaps by commitment, and is handled as mentally ill by the "direct and implied attitude of physicians and the whole treatment setup, all of this is impressive to the patient, and he will tend to adopt it as his own view of himself." ¹⁰

Ironically an aftermath of hospitalization imposes a psychological burden upon those less able or equipped to carry one, namely how to relate the fact of hospitalization in various situations which come up during the course of one's life. The formerly hospitalized juvenile is often thrown into a quandary when he must decide whether to acknowledge that he has been in a mental institution. The issue is not a matter of practical judgment alone, but of conscience which touches one's moral being and thus becomes a source of stress. When the topic crops up it is not usually in casual circumstances but at a crucial point in one's life. We refer here to employment, the military, application for a

driver's license, and the proposal of marriage.

The case of enlistment may be of special import. For some the opportunity for military service has much significance. It is a chance for a new start, to prove one's self, and to learn. The service can provide escape from an unsatisfying life or to give one a breather, the chance to mark time and consider one's future at leisure. The opportunity for military service and its potential benefits may well be blocked for the formerly hospitalized juvenile.

The formerly hospitalized juvenile is often thrown into a quandary when he must decide whether to acknowledge that he has been in a mental institution.

A person is also confronted with his past when he completes application forms such as a driver's license. It is usually necessary for the previously hospitalized person to obtain a certificate to the effect that he is recovered, or has been released unconditionally. Otherwise he must submit to a special examination.

What does one tell one's friends and intimates? Does one inform the girl to whom he wants to propose that he has spent time in a psychiatric hospital, i.e., is a former mental patient? The stress and inner turmoil these moments of truth may engender should not be minimized.

What precautions can be taken to lessen the realization of the concerns expressed in this paper. A preliminary consideration is motivational since decision-makers will act in the absence of external pressures only if they believe the reasoning and evidence cited has merit. If the reader is so persuaded, a policy review and the development of clear guidelines is called for. Among the points recommended for in-

clusion should be 1) that admission of juveniles to inpatient status be on the basis of a positive choice, i.e., clinical findings clearly indicate that the condition justifies admission, and 2) the institution has the resources to treat the child. Conversely, the mental hospital should not be used as a dumping ground for juvenile rejects whose condition is primarily a manifestation of social pathology rather than mental illness. In this regard one has good reason to suspect that the term 'voluntary admission' is an ironic semantic ploy since it is not likely that the juvenile is doing the volunteering. Parenthetically one of the arguments for the hospitalization of certain adolescents creates a paradox. While acknowledging admission of some juveniles as inpatients is inappropriate, it is justified on the basis of a lack of adequate alternative living arrangement in the community. Yet the very act of hospitalizing these people serves to reduce pressure, thereby lessening the demand for, and forestalling the creation of, substitute resources.

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Henry P. David, Ph.D.

Mental Health and Social Action Programs for Children and Youth in International Perspective

Forty countries were surveyed in 1968 in an effort to gather information on innovative services for emotionally disturbed children, retardates, juvenile delinquents, and the culturally deprived. Special consideration was given to the organization and delivery of services, the contributions of non-professional manpower, and preventive endeavors. The author summarizes trends in various countries and notes the benefits and experience gained with group care and non-professional staff.

Cultural Deprivation and Group Care

As noted by Eisenberg,³ one of the major issues facing mental health specialists and others caring for children is the "deprivation syndrome." It is, in varying degrees, a complex of intellectual retardation, personality defect, and social maladaptation, generally produced by the unavailability to the child of the biosocial necessities for normal growth and development, usually as a consequence of gross social pathology.

Worldwide evidence reflects the significant correlation between economic deprivation and maternal ill health, poor pre- and postnatal care and malnutrition, and the predictable results. Deprived youth receive little intellectual stimulation at home, are barely motivated to attend school, and must crowd into inadequate classrooms. They tend to live in decaying neighborhoods, rich

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only in opportunity for trouble and characterized by value systems opposed to those of the dominant culture. Rates for parental disorder, death, and desertion are high. Such children become premature and inadequate parents themselves, fated to repeat the cycle of deprivation for a succeeding generation.

The concept of substitutes for parental care is not new. Examples may be found in all modern societies. The Western world,

differences both in social attitudes and in the alertness of children, depending on how early they are placed in institutional type care and how much they have been deprived of parental attention and family life.

To be accepted in a society, a children's institution must establish its "legitimacy" as a social structure. The prevalent view of most North American institutions is that they are deviant settings for child rearing, claiming to work primarily with problem

... the basic barriers to the improvement of child care are socio-economic ...

strongly influenced since the turn of the century by Freudian concepts and a laissez-faire philosophy, has leaned toward substitution in the form of individual child care in foster homes. Manpower shortages, tight housing conditions, and high employment rates among women, as well as ideological considerations, have tended to favor group care in the predominantly Catholic lands of Europe and Latin America; in Israeli collective settlements (kibbutzim); and in the socialist societies of Eastern Europe.

There is considerable variation among Eastern European group care programs. Meers and Marans⁵ observed that some babies are placed directly in residential institutions, e.g., special facilities established for children of graduate students at universities. Children of working parents may spend five days a week in an institution and the weekend at home. Other youngsters go directly to the nursery from about three months of age onward; they continue in day care throughout their preschool life. Because of competition for available space in the day care centers, some children are not placed until they are two or three years of age. It is Meers' impression that there are

children, the dependent, neglected, delinquent, retarded, and emotionally disturbed. They may be called "training schools" or "hospitals" whose goal is the successful return of the child to his natural family or a foster home environment. In sharp contrast, much of the impetus abroad stems from the ideological conviction that group care is superior to the natural family environment.

The North American reader of the literature may be troubled by an apparent similarity of many of the Eastern European programs to the kind of orphanages, junior republics, and church operated, or public, institutions which flourished in the United States several decades ago. Such analogies would be very superficial. In contrast to the "outsider" status of group centers in the United States around the turn of the century, group care abroad is a significant part of the mainstream of society. Prevalence of the kind of psychological deprivation reported by Bowlby, Spitz, and others appears to have been sharply reduced in most modern facilities. What is perhaps more troublesome is the absence of systematic longitudinal or other research data from the Eastern European programs. When

some indication of deprivation has been reported, it has usually been concluded that such retardation is minimal and can be reversed through later education, just as character structure and values of self and others are viewed as modifiable consequences of early education.

After noting the controversies and warnings, the question must still be asked whether, under conditions assuming adequate staff ratios and finances, infant group care is not an acceptable substitute for families crippled by economic and social disadvantage. Present U.S. research has amply demonstrated the vicious circle effect and damage to mental health under conditions of socio-economic and cultural deprivation, which affect nearly a quarter of U.S. children.⁶ Infant day care programs might open the way for breaking the self-propagating set of social tragedies for this population.

If the concept of a social need to innovate is accepted, are we prepared to make fiscal investments comparable to those incurred, for example, in the Soviet Union or Israel? Are we ready to recruit, train, and reward

turbid or rioting outcasts? Can we change deep-seated and powerful socio-cultural traditions?

Juvenile Delinquency

Among the most baffling social maladies of the century is that of juvenile delinquency. A worldwide phenomenon, it may vary qualitatively and quantitatively from country to country. In recent years Sweden had the highest rate of juvenile delinquency: 3% of its teen-agers passed through the courts (compared with 2.3% in the United States). Teen-agers commit over 20% of Japan's total crimes versus 12% in the United States. In Israel the number of arrested juveniles has doubled in the past decade.⁷

There is at least one significant difference between juvenile statistics in the United States and other countries. Nearly everywhere else, a youngster is brought to court only if he breaks a law which would also constitute a crime when violated by an adult. In the United States, the definition of juvenile delinquency has become so all-encompassing that children enter the statistical records for truancy, stubbornness, leaving home, curfew violations, etc., none of which would be termed a law violation in other lands.

In working with delinquent youth (regardless of legal definition or terminology) there appears to be near global consensus, emerging from numerous international seminars and conferences, of the desirability of bringing a more therapeutic-rehabilitation orientation to correctional institutions. However, observations of juvenile centers also reflect the considerable divergence existing between institutional aspirations and actual practices, requests for staff and operating personnel, and innovative treatment concepts and implementation. Rec-

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adequately more child care staff of merit and dedication? Can we produce the conditions that will give status and recognition to those working with disadvantaged children before such youngsters become dis-

ommendations for coping with resistance to perceived threats to existing staff structures and institutional methods of control are widely discussed.

Although extensive surveys have been conducted and reports written, it is virtually impossible to offer a precise estimate of the extent to which mental health principles have actually penetrated work with delinquent youth. There are considerable differences between countries and between types of institutions within any one nation. Nearly all reflect some dissatisfaction with progress made so far. Countries which compared to others have high staff:inmate ratios and a complement of mental health specialists are no more content than countries still aspiring to such levels.

Ideology enters the picture in determining how a given society deals with delinquency. In some cultures, notably the United States, a relationship between cultural deprivation and/or mental disorder and delinquency has become well accepted. There is public demand for more and better professional services. In sharp contrast, the Soviet view is that a delinquent lacks the kind of moral education essential for honest participation in a communist society. As Conrad¹ observed: "In the United States, the offender is likely to be an unfortunate person needing treatment. In the Soviet Union, he is an unfortunate person needing opportunities to learn."

After years of denying its existence, the Soviet Union now reluctantly accepts juvenile delinquency as a part of Soviet life, a social phenomenon ascribed to increased industrialization and greater affluence. But, there is frequent insistence that the problem is not as severe as in the West. After all, it is said, Soviet youngsters do not have easy access to automobiles, cannot readily purchase guns, and are unable to shirk

socially useful labor without attracting the attention of authorities. Assuming that, in fact, the U.S.S.R. does have a lower rate of juvenile delinquency than most other industrial countries, it would be most worthwhile to study the extent to which these differences may reflect upbringing (such as in a collective), the effects of contemporary social conditions and changing family values, and a new kind of Soviet affluence. Soviet pedagogues maintain that pre-delinquent behavior can be handled more effectively by the combined help, censure, and pressure of the peer group in the collective than by professional mental health workers.

When it comes to "doing something" about juvenile delinquency, the literature reflects a plethora of approaches, from individual psychoanalysis to severe punishment. It is also evident that many well-intentioned endeavors have had limited effect on the rising delinquency rate. Constructing housing developments and playgrounds, organizing boys' clubs, reducing the number of working mothers, mending broken homes, and sending everyone to child guidance clinics have not, in themselves, had far-reaching effects. The experiences reported from Denmark, German Federal Republic, India, Japan, Sweden, Soviet Union, Canada, Philippines, Switzerland, Israel, Turkey, Austria, England, Poland, and Yugoslavia suggest that an impact can be made by providing meaningful jobs, lowering the school-leaving age for those entering vocational training programs (e.g., 14 years in Denmark), and by qualitatively strengthening the youth work of the police, parole, and volunteer agencies. Particularly effective have been the pedagogic-therapeutic programs in Denmark and the Federal Republic of Germany; the therapeutic use of work and vocational training in the Soviet Union and Canada; and the enlistment of volunteers in pre-

ventive endeavors in Turkey, Poland, and Yugoslavia.

Effective delinquency control is something that requires constant attention. In many parts of the world, particularly in the collectivist societies, large groups of citizens appear to be far more involved in preventive work than is the case in the Americas. Good probation, small institutions, adequate school counseling and curricula, better police and understanding judges can rehabilitate troubled youth. Tunley⁷ reported that many communities abroad, less fortunate economically than the United States, spend a far greater proportion of income on child welfare. Following his global survey, he recommended: (1) having available a variety of work and training opportunities which will keep youngsters off the streets and busy at something they like and believe has a future; (2) revision of school laws to allow certain students to leave earlier and/or adding vocational work programs into the schools; and (3) spending more money for more adequate probation, police, and court services along with smaller rehabilitation units.

The impression which emerges from the literature and from personal observations is that good ideas may be found in many parts of the world. Often they have been developed by and are dependent on key people who have attracted highly motivated followers but have failed to inspire imitative programs either in their own lands or abroad. It seems that in the field of correction change is more difficult to achieve by directive or example. Though change may be advocated by administrators, those involved in daily operations tend to be more concerned with problems of control and with restrictions. Change *per se* is feared and often misunderstood. The evidence suggests that neither the variety of available services nor the increasing so-

phistication of pioneering programs have thus far had a marked effect on the worldwide rise in delinquency.

Manpower Trends

The recognized shortage of professional and non-professional mental health and child care workers is global. It is particularly acute in residential facilities, whether for emotionally disturbed, delinquent, or deprived youngsters. Many European residential homes, schools, and observation centers are staffed by a small number of professional workers and a larger number of child care workers whose titles may be *educateurs*, orthopedagogues, house parents, or specialized teachers. It is they and their activities that create a center's therapeutic or non-therapeutic atmosphere. Although many directors of institutions regularly impress their visitors and government officials with a desire for more formally trained workers, there is often evident satisfaction with the existing staff, many of whom are self-taught. Their attitude and their success or failure to implement the director's policies are basic to the institution's milieu.

The treatment model in most American children's centers places primary emphasis on diagnosis, case work, and group and individual therapy conducted by professional workers. As noted by Linton,⁴ the professionals furthest removed from the daily life of the child have the highest status and rewards, as well as control over the prescribed regimen; those individuals with the closest personal contact with the child and his actual behavior frequently receive the lowest status and the poorest rewards for their work. One reason for this situation is that the American model emphasizes psychological and pathological aspects of behavior. In both theory and

practice the importance of psychological understanding is stressed. The medical model prevails, with other disciplines formulating their treatment approaches in conformity with that concept. While an individual worker may achieve a high level of accomplishment in selected facilities, child care workers, as a group, have not attained high visibility, status, or recognition in the United States.

In contrast to American practice, newer professional roles have emerged more rapidly in Europe. Particular attention is focused on "educateurs" in France and "ortho-pedagogues" in the Netherlands. The training of educateurs has been well developed in France for more than two decades; the graduate educateur is in considerable demand throughout Europe. He is perceived as a member of an independent discipline, not subordinate to medicine, psychology, social work, or education, nor is he especially trained in diagnosis or therapy.

He is neither a teacher, expected to raise a maladjusted child to a particular academic level, nor a houseparent or attendant who attempts to control the behavior of his wards. Rather, the educateur is a highly trained professional youth worker who is primarily concerned with the total life process of the individual youngsters in his group. He is prepared to utilize all the leisure moments of the child's life, and to program this free time so as to facilitate physical, moral, social, and intellectual development.

In many French institutions for disturbed children, as well as elsewhere on the continent, educateurs are the key figures in the total life space of children; they are deeply involved in day-to-day reeducation and resocialization. Educateurs work in and frequently manage institutions for delinquents, retarded, physically handicapped,

... the professionals furthest removed from the daily life of the child have the highest status and rewards, as well as control over the prescribed regimen . . .

the socially and emotionally disturbed, the homeless and neglected, etc. They are also trained to function as street-workers in slum areas. While traditional professional roles of psychiatrists, psychologists, social workers, and teachers remain essentially the same, the difference lies in the fact that the daily management and direction of an institution is in the hands of an educateur-director and his staff of educateurs.

In much of the world the question of who qualifies for child care work, with what training, obtained in which kind of institution, is an open one. There is general agreement that some people would never be suitable for work with children regardless of length of training or quality of work performed. Others seem to work well without any specialized training. There is much discussion about the location of training programs, whether on the job or in a university or special school, or some sort of combination. There is debate on whether to require a watered-down version of professional training, operating from the same basic assumptions taught to professional disciplines, or whether to approach training from quite different perspectives. Much consideration is given to the contributions of volunteers, e.g., the *curateurs* in Poland and youth workers in Denmark and Yugoslavia.

Literature and personal observations reflect a growing conviction that those closest to the disturbed child's daily life have the greatest influence on reeducation and re-

socialization processes. The medical model is undergoing reexamination and the hierarchy of professional roles is being reconsidered. Perhaps the time has come for a more systematic transnational survey of who does what, where, and how, for which purpose, and with what results. Conjecture or uncontrolled imitation are less than adequate. The increasing shortage of skilled professionals amidst burgeoning demands for services calls for innovative enterprise. Are we prepared to change the status quo?

Conclusions

If there is a lesson about programs for culturally deprived youth and juvenile delinquents that can be conveyed from the material gathered for the (U.S.) Joint Commission on Mental Health of Children, it is that considerable improvement can be attained in nearly every country if we will only apply, or adapt, already available knowledge. There is much to be learned from the suggestions for extended social security and/or mandatory sickness insurance benefit schemes, effective group care for deprived youngsters, vocational training for school drop-outs, better police, court, and probation facilities, training of non-professional child care workers with more status and reward accorded for services of excellence, and encouragement of qualified volunteers. Implied in these recommendations is a recognition that the basic barriers to the improvement of child care are socio-economic, and that amelioration requires a departure from the exclusively medical model of child mental health services to one of socially shared public responsibility for children, with emphasis on strengthening individual assets instead of focusing on pathology.

In this time of rapidly shifting values and growing alienation of youth, it is essential to review where we have been and where we are going.² Statistics demonstrate starkly that many modern systems of organization and delivery of care, and of individual payment of services, are antiquated and fail to meet the health, education, and welfare requirements of large segments of the world's children. Direct comparisons are elusive. There are differing approaches and ideologies in diverse geographic regions. However, no one country, no one profession, and no one ideology has a monopoly on innovative programs. It is time to learn from each other, from our mistakes as well as from our successes.

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Anthony F. Donofrio, Ph.D.

Child Psychotherapy— Help or Hindrance?

The author discusses the diagnostic pitfalls psychologists encounter in dealing with children and urges a greater understanding of children's problems. These, he believes, can be grouped in three categories—problems arising from deprivation of basic psychological need, those arising from constitutional and developmental factors and those arising from minimal neurological damage or dysfunction. He proposes alternatives to child psychotherapy which include working with parents and other significant adults in the child's life.

Introduction

Twenty-two years of experience in child guidance clinics and private practice have convinced me that child psychotherapy is, for the great majority of children referred for that purpose, a hindrance rather than a help. Other authorities have come to a similar conclusion.

In his presidential address to the nation's psychologists, Nicholas Hobbs stated: "We have become increasingly convinced that a major barrier to effective national planning for emotionally disturbed children is the professional's enchantment with psychotherapy."⁶

Several studies conclude that child psychotherapy has not proven its effectiveness. Shepherd, et al.¹¹ at the University of London, attest to this conclusion. Fifty children from a school population were carefully selected to match the symptom picture of fifty children who were about to start clinic therapy. A follow-up study after two years showed almost identical percentages of improvement in the treated and non-treated groups. It appeared, then, that therapy was not demonstrably superior to the passage of time. Of further significance was the finding among the therapy group that the number of therapy sessions bore little or no relation to the status of "improved," "unchanged" or "worse." Neither could it be argued that those children showing most improvement on minimal treatment were those who were least

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disturbed, because, of the nine clinic children originally rated "severely disturbed," eight were improved at follow-up but only two had received more than five sessions with a psychiatrist. Levitt⁸ summarized numerous follow-up studies on child therapy and concluded: "The present evaluation of child psychotherapy, like its adult counterpart, fails to support the hypothesis that treatment is effective. Another review by Lewis⁹ comes to a similar conclusion. Finally, Thomas, et al.,¹² in a ten year longitudinal study (from infancy) of temperament and behavior in 136 children, found parent guidance the effective method of helping child and parent; in very few cases did they consider psychotherapy useful. The average number of sessions undertaken per couple was 2.9.

Scope

In the sections ahead, we plan to treat first the diagnostic pitfalls for many psychologists upon whose evaluations the social worker, educator, and psychiatrist often rely heavily. The second aspect will describe three major categories comprising children's problems, namely those arising primarily from deprivation of basic psychological needs, those arising from constitutional and developmental factors, and those arising from minimal neurological damage or dysfunction. Finally, in view of our essential rejection of child psychotherapy, we will propose other concepts for the rehabilitation of the child in these three settings.

Psychomisdiagnosis

"One of the most puzzling and distressing problems that confronts clinical psychology today is the persistent report by many psycho-diagnosticians of clinical observa-

tions, which, by objective evidence, clearly appear to be erroneous."² The authors point up the failure of researchers to substantiate many of the diagnostician's interpretations of projective test responses. The agreement in interpretation, on the part of many practicing clinical psychologists, in the face of "massive negative experimental evidence," leads the authors to posit a "systematic error" in which said clinicians reinforce one another, resulting in an "illusory correlation." The authors conducted six studies to show the genesis of widespread but erroneous diagnostic interpretations.

From the vantage point of a psychiatric guidance clinic serving a large area with its many school districts, we heartily endorse the above indictment. Misdiagnoses with conformity in language or semantics are rife; the heavy reliance on projective tools whose interpretative validity is very questionable, indeed, distressing.⁵ One sees many parents confused and emotionally upset. Some have already been referred to private psychotherapists and are seen, later, financially and emotionally drained.

Our psychodiagnostic tools consist of "objective" and "projective" tests. The objective tests consist of measures of cognitive or intellectual functioning: attention, concentration, memory, perception, learning and subject achievement. These are the psychologist's most valid and reliable tools with which much important information can be gained about the child through the test results and the examiner's observations. Not infrequently, however, does one find only a paragraph on this aspect while a page or two of dire dynamics issue from the projective tests. That the mother protests her child is not emotionally disturbed, but "can't get his school work" is dismissed as coming from a defensive *ignominy*. *Too often has mother been in-*

tuitively right and the psychologist wrong. Marked variation in performance on the eleven subtests of the Wechsler Intelligence Scale for Children is typically attributed to "anxiety" or "emotional block" and psychotherapy recommended. More often

How often husband and wife have blamed each other, suffered cumulative guilt, and fallen into a vicious circle because of our professional misdiagnoses and blind-spots.

than not (along with Clement and Peters),⁴ we have found this untrue in our clinic experience—a cart-before-the-horse phenomenon. In the words of Hobbs⁶—"If a child feels he is inadequate in school, inadequacy can become a pervasive theme in his life. . . . Underachievement in school is the single most common characteristic of emotionally disturbed children. We regard it as sound strategy to attack directly the problem of adequacy in school for its intrinsic value as well as for its indirect effect on the child's perception of his worth and his acceptance by people who are important in his world. . . . School is the very stuff of a child's problems."

Much of the misdiagnosis of childhood problems by psychologists can be attributed to the lack of proper and adequate exposure to certain areas of child study. We refer to child, developmental, and constitutional psychology as well as the recent focus on minimal neurological damage or dysfunction. *The average practitioner is over-exposed to, and overawed by, child analytic theory.* Barclay,¹ as a member of an APA committee on the training of psychologists reported finding that less than 10% of clinical psychologists "had any exposure to courses in developmental or child psychology." He also comments on the reluctance

of psychologists to diagnose mental limitation or retardation. We find too little credence given to a mother's knowledge of her own child's behavior.

Sources of Children's Problems

For didactic purposes, we have divided the sources of children's problems, seen in clinic and private referrals, into three categories. We are fully aware that in actuality these will overlap, but usually one of the categories can be assigned as the primary factor in diagnosis. There are those problems arising primarily from the deprivation of one or more basic psychological needs; those arising from constitutional and developmental factors; and finally those arising from the "sub-clinical" or minimal neurological damage or dysfunction.

We may posit four basic needs in the child: love or affection, security, recognition, and a sense of achievement or accomplishment. I would add a fifth—the need for a wholesome foundation in religion, particularly for its existential implications in adulthood.

Constitutional differences in children have struck me forcefully in the years I have served a foster home agency. There is the infant who "jumps out of his skin" when he drops a rattle on the examining table and who is sensitive to the many vicissitudes of weaning and rearing. In contrast stands the infant whom you can "rough up" and who comes back smiling all the time. One sees them as toddlers, advanced to the older nursery, the one shy and relatively unresponsive, the other friendly, forward, and of happy countenance despite the same setting. Thomas¹² and his coworkers have documented these differences in a ten year longitudinal study from infancy. They are extricating parents from the guilt engendered in them in

the past by psychoanalytic blindness to such innate factors.

The ignorance of developmental psychology in clinicians, pointed out by Barclay,¹ is seen when slow maturation is interpreted as "regression." Knowledge of developmental behavioral patterns, of "ages and stages," is indispensable. Without adequate

Help for the child's ego must come, therefore, via the education and guidance of the "significant adults" in fulfilling the needs of love, security, recognition and achievement.

knowledge of constitutional and developmental psychology, the psychologist is of little value—if not of actual harm—to parents.

The diagnosis of minimal neurological damage or dysfunction is relatively recent. One finds the analytically oriented professional poorly informed and often quite resistive in this area. The regular neurological examination is usually negative and the EEG may also be negative, yet converging evidence can be obtained from history, current behavior, and psychological test results. Behavior includes a number of the following traits: hyperactivity, distractibility, hyperexcitability, perseveration, awkwardness or poor coordination, marked immaturity, and a learning disorder. I would estimate that 30% to 40% of the referrals to child guidance clinics fall into this diagnostic category.

Programming vs. Psychotherapy

For the purpose of this paper, "childhood" can be considered to extend to the 11th year, where Gesell & Piaget agree on a major demarcation in the evolution of the ego. Piaget, in his intensive research

on the development of cognition, finds the beginning of the abstract, "future" oriented characteristics of adult cognition, at the 11th year. Gesell sees the equable and docile 10th year as really the end of childhood with glimpses of the adolescent in the 11th year; the ego is embarked on its course toward independence. The term Programming is borrowed from Redl and Wineman¹⁰ who point up the practical uselessness of psychotherapy in dealing with their disturbed aggressive children in the Pioneer House experiment.

If one grants the premise that a child's psychological well-being depends on the fulfillment of his basic needs, and that his ego is still in a dependent relationship, then how can one, or even two hours a week of expensive play or interview sessions truly serve this child's ego when in the other 167 hours, the significant adults in his life are often unwittingly blocking need fulfillment by omission or commission, by misconception and confusion.

Although we categorized in first place, "problems arising from the deprivation of basic psychological needs," we find in actual practice, along with Thomas et al.¹² that this category rarely stands alone but is usually inextricably interwoven with the other two categories. We refer to the constitutional factors of the given temperament and developmental stages, and to minimal neurological dysfunction. It was from the "difficult" children (temperamentally) for the most part that Thomas et al. derived their "clinical" group—those whose parents needed guidance. The child who comes equipped favorably in temperament and constitution (includes intellectual efficiency) comes by much of his basic needs among peers and his significant adults almost automatically.

Programming for ego-building involves discerning or defining the child's tem-

perament, intellectual level and learning efficiency, developmental stage, and neurological intactness, and then furnishing concrete guidance to the significant adults in his life toward the goal of fulfilling realistically his basic needs.

How to recognize, accommodate to, and minimize the effects of difficult traits of temperament in the child is a task for parent and teacher. In this regard, **Your Child Is a Person**³ is an excellent contribution for both professional and parent. Problems arising from developmental factors, such as "maturational lag" with its concomitant school unreadiness, are rather easily solved if they are diagnosed parsimoniously as just that and not "emotional disturbance" or "overprotection." Two paperbacks (Dell) of the Gesell Institute, "Child Behavior" and "Parents Ask," and a recent publication of Ilg and Ames,⁷ are of immense value for guidance in this aspect.

How to help the child with a minimal brain damage is most challenging. He and his parents have been most misunderstood because his "crippling" is invisible. His coping mechanism is faulty; hence, his needs are excessive. If psychotherapy is not the answer for the child with an intact central nervous system, it certainly is not for the minimally damaged child. Correct diagnosis is of first importance—too many are misdiagnosed as neurotic children or latent schizophrenics. Parents need several sessions of education and concrete guidance; medication is often of much assistance. The school must adapt its program to his special learning difficulties to insure (in some measure) the fulfillment of the needs of achievement and recognition. Associations of parents of brain-damaged children are mushrooming throughout the country, seeking better programs of education and service.

Sunshine and Rain: While specific principles of guidance apply to each of the categories of children's problems, there is a basic principle which is crucial and transcends all conditions. In my guidance sessions with parents, I call it my "two to one ratio" or "Sunshine and Rain." A plant needs rain but much more sunshine to flourish. Just so, the child needs correction, scolding, punishment (negatives); but, more affection, humor, praise and recognition (positives) in a better than "two to one" ratio.

Condition of the Parents: How, we are thinking, can we effect a change in the child's behavior if the parents are neurotic and there are perhaps marital conflicts? First, I would draw attention to a factor so often overlooked by professionals in our field—the contribution of the child's behavior to the relationship between husband and wife. We refer to behavior based primarily on major constitutional or neurological deficits in the child. How often husband and wife have blamed each other, suffered cumulative guilt, and fallen into a vicious circle because of our professional misdiagnoses and blindspots. Even with neurotic disturbances in parents that antedate their parenthood, we have found that the child can be substantially helped with a clear diagnosis and concrete guidance, without attacking the mother's neurosis. Marital counselling and individual counselling for the parent are certainly worthy of attention concomitantly if feasible.

The Guidance Professional: What of the "condition" of the guidance professional? Love and compassion are necessary attributes. They do not come with the degree. Some portion of these attributes derive from knowledge of the human personality and some from humanistic and religious considerations. The importance of these attributes becomes clearer when

we reflect that a large proportion of our clients would fall into the category of the "less lovable"—often for reasons largely beyond their control.

While we have presented reasons for the elimination of child psychotherapy under eleven years of age, we do not intend any inference that we regard it as of primary importance above that level. "Programming" is still considered primary for the older child and adolescent; a brief period of psychotherapy may be secondarily helpful.

Conclusions

We have challenged the practice and the claims of childhood psychotherapy. We see it as essentially and practically useless, inextricably bound up with yet-to-be proven child analytic concepts, misdiagnoses and aduItmorphic ambiguities. We see here a violation of the Law of Parsimony.⁶ In practice, we have seen many parents who have gone through the ordeal of a year or two of financial drainage, and compounded confusion. We suggest with Barclay¹ that graduate training schools re-assess their programs, and that the term and process of "Programming" be substituted for that of "Psychotherapy" for children—programming for ego build-up, through need gratification at the hands of the significant adults in the child's life. We do not agree with the hue and cry for more psychiatric clinics for children. What we have will suffice when "professionals' preference for deep explanations (psychoanalytic) and derogation of all else as superficial"⁶ is replaced by the proper scientific stance of

the Law of Parsimony; i.e., where one or more explanations are at hand, we must accept the simplest first.

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James K. Whittaker, Ph.D.

Training Child Care Staff: Pitfalls and Promises

The author outlines procedures for the training of child care workers. This can range from life space supervision in which the supervisor demonstrates techniques, to one-to-one supervision in an office setting to group supervision. All members of the staff, from the janitor to the administrator should participate in training.

This paper will attempt to outline a number of specific guidelines for the establishment of a child care training program, as well as explore several potential pitfalls inherent in undertaking such a venture.*

To begin with, we must ask ourselves the question: "Training for what"? It goes without saying that what the child care worker does in an institution should be based, in large measure, on the problems and needs of the children in his care. Too often, what the child care worker does has more to do with organizational expediency, or with professional needs, than with the needs of the children. It would appear that, whichever professional group occupies the position of leadership in an institution, a great deal of time and energy is spent in maintaining rigid status hierarchies and

role distance between the various professional groups. It has reached the point where the quality of an institution is often judged solely on the number of different specialists which it employs. In the course of a single week's time, the child might be expected to see his: psychotherapist; group therapist; family case worker; occupational therapist; recreational therapist; music therapist and so on. We expect this of the child, despite the fact that relatively few problem children come to the institution with such neatly encapsulated and well defined problems.

In such an institution the child care worker's role would actually consist of little more than that of a good traffic manager, who makes sure the child is ready for his string of daily appointments. Training child care staff would probably cause problems in such an institution, since the indi-

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* Based on the author's clinical experience as assistant director of the Walker Home for Children in Needham, Massachusetts and as a member of the senior clinical staff of the University of Michigan Fresh Air Camp.

vidual child care worker would not be allowed to do anything. A far more fruitful approach would be to begin with the problems of the children in care and to design the child care worker's role as the key role, since he is the person who is closest to the child and has the greatest opportunity for potential influence on him.

Having asked the question: "Training for what?", we must immediately ask another question: "Who shall be responsible for the training"? Again, we must report that in many settings, the choice of supervisor is more a reflection of professional needs than it is of the training needs of the child care worker.

Consider, for example, the plight of the beginning child care worker who really needs to know a great deal about how children function in a 24-hour-a-day setting, but who ends up being supervised by a social worker, psychiatrist, or clinical psychologist whose only contact with the child may be in the context of the 50-minute therapy hour, within the sanctuary of his office. One obvious way of avoiding this problem is to use senior child care workers as supervisors. The senior, more experienced worker possesses just the kinds of information that the novice child care

In what is often a painful moment of truth, the child care worker sees that it is not easy for his supervisor to calm a writhing child in the throes of a temper tantrum. . . .

worker needs to know in order to carry out his duties within the institution. These include such things as: a knowledge of the rules and routines of the institutions, some knowledge of the individual children, some

simple behavior management techniques and some suggestions about things to do with children for fun. Later on, as the new worker becomes more proficient and secure in his role, he may seek added explanations from other professionals as to "why" a child acts in a particular way, or what the family dynamics are in a given case. Ideally, the institution should provide for different levels of training, ranging from direct line staff supervision, through informal meetings with agency professionals, up to and including participation by line staff in case conferences.

Whoever undertakes the supervisory task, a certain number of pitfalls are evident and should be avoided. It should be the responsibility of the supervisor to define for the child care worker what will be the basis for their supervisory relationship. This could vary from an intense involvement in what amounts to personal psychotherapy, to a problem solving, teaching centered relationship. It is imperative that whichever format is used, the child care worker be made aware of it. To do otherwise, is to be faced with the situation of some child care workers who entered supervision expecting some sort of insight producing psychotherapy, feeling cheated when they do not receive it and of other child care workers who feel they are being unduly "caseworked", when all they really wanted were some concrete suggestions for how to manage a child's behavior.

Life-Space Supervision

In this form of supervision, the professional moves through the life-space of the ward, or cottage offering assistance and support to the child care worker as he is invited to do so. In this way, he is given an opportunity to model a desired way of managing a child's behavior, rather than just talk

about it in "office supervision". Care should be taken, of course, to move in on a situation only when signalled by a child care worker. The method of life-space supervision is not without its hazards, particularly for the professional. Once outside the sanctity of his office and the protection of the 50-minute therapy hour, the therapist's halo becomes slightly tarnished and his fallibility and mortality become plainly visible to all. In the life-space of the institution, the children act as the "great levelers". They are singularly unimpressed with Ph.D.'s and A.C.S.W.'s and couldn't care less how well versed one is in psychological jargon. In what is often a painful moment of truth, the child care worker sees that it is not easy for his supervisor to calm a writhing child in the throes of a temper tantrum, stop a fight, put an end to a scapegoating session, or convince a timid child that it is alright to join an activity. The child care worker will see his supervisor: make mistakes with children, get angry, say the wrong thing, have nothing to say, and, literally, fall flat on his A.C.S.W. when trying to help restrain a wildly angry adolescent. In short, the child care worker will see the supervisor experiencing all those things which he himself finds so frustrating.

Given the fact that a supervisor has a strong enough ego to operate sometimes in the "fishbowl" of the milieu, the type of training that the child care worker receives will in the long run be most beneficial and lasting. It drives home the message to both supervisor and child care worker that there is no easy way of dealing with all of the problems which disturbed children create in an institutional setting. It tends to narrow the gap which child care workers so often feel between themselves and their supervisors and above all it sensitizes both supervisor and child care worker to the spe-

cial problems which each faces in working with the children and creates a climate which makes working together more than just a nice sounding phrase.

Staff Training for All

It is entirely possible that an administrator could set up an excellent child care training program and still be missing a significant amount of interaction between children and adults, if he concentrates his efforts only on those people who work directly with the children. For those of us whose business it is to relate to children, it is sometimes difficult to admit that certain children will prefer the company of the cook, or maintenance man to our own. Unless we make some attempt to include this group in our staff training, we essentially lose all control over what happens in these encounters. Polsky¹ and others have pointed out the potential dangers in an institution which rigidly separates its professional and child care staff from its house-keeping and maintenance staff. Often the special techniques needed to work with emotionally disturbed children are a source of bewilderment to untrained maintenance and kitchen staff who raised their own children under the maxim: "Spare the rod and spoil the child". For this reason alone, they should be included in some part of the agency's training program.

Group Supervision

It is important to make clear from the outset the nature and purposes of the group. For example, will the leader assume a directive teaching role, or will he take a more laissez-faire stance? Will staff be urged to bring up criticism of each other's work, or will this be left for individual supervisory sessions? Will the group focus

mainly on the children, or on staff relationships?

Another point centers around group decision issues; here, the leader should make clear to the members of the group that there are different phases of decision making in groups: 1. A phase of *Orientation* in which the members acquaint themselves with the various facets of the problem; 2. A phase of *Evaluation* in which the various alternatives for action are discussed and compared; 3. And finally, a phase of *Control* in which the members decide upon an action strategy and take steps to implement it.²

Problems often occur in staff groups when child care workers try to arrive at a "quick fix" solution, without first becoming knowledgeable about all aspects of the problem and all of the avenues open for action. Child care workers eager for concrete suggestions may come away grumbling that, "All we ever do is talk about problems, we never decide anything". It should be pointed out by the group leader that a very fruitful session can be held in which the staff simply tries to find out exactly what is happening, without settling upon any immediate solutions about "what to do".

On a related point, it is essential to make clear to staff groups exactly how much decision making power they have and in what areas they may exercise it. To do less than this is to invite ill feeling and create barriers between the administrator and his staff. It is the author's personal feeling that while the child care staff should participate in decision-making, a children's institution cannot be run on the model of a participatory democracy. Some decisions must be reserved for the clinical, or executive director and these should be made clear from the beginning. Typically, they would include ultimate decisions on intake

and discharge of children, the hiring and firing of staff and matters of major policy change.

Conclusion

One of the paradoxes in the question of child care training is that the problem seems to be less with the people we would like to train and more with ourselves who would do the training. It is with the administrator who thinks that staff training consists of subscribing to a few professional journals and having a few child care workers sit in and listen to a case conference now and then. It is with the therapist who sees no room in his narrow conception of the treatment model for child care workers to be anything more than custodians. It is with the case worker whose only venture outside of his office is to refill his coffee cup, because to do otherwise would be outside of his "professional role". Indeed, the problem is with any of us—regardless of our professional orientation—who refuse to accept the fact that the single most important and influential person in the institution is the child care worker. If we truly participate in helping him to work with the child for all of the other 23 hours—making available our expertise, while drawing on his vast practical knowledge and skill—then "training" in the formal sense of the word becomes less of a problem and we will be well on the road to developing a truly therapeutic milieu.

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David Coogan, M.S.

Henry K. Kaplan, Ph.D.

Moving the Hard to Move

The authors discuss a program for adolescents who are on their way to becoming chronic patients. They found that the youngsters responded favorably to a combination of constant direction and pressure with activities designed to foster a sense of independence.

How does one go about developing a program for that very hard to place adolescent group—the inadequate, intellectually limited, academically retarded, sometimes psychotic teenagers, who become hospitalized for a variety of reasons but whose reason for staying in the hospital boils down as much to fear of the world outside as it does to the community's difficulty in finding a place for them?

This article describes our program for the "non-academic adolescent", touching on both our successes and failures and spelling out what we feel can be done to overcome or circumvent the fear and threat of independent living that is experienced by our patients.

At Mendota State Hospital we have had a school program since 1962 which has been able to more and more adequately educate a broad spectrum of our high school level patients. For the above defined group we "watered down" our curriculum and added some special features, such as budgeting and filling out job application forms, which

we felt could be useful. This was carried on in the classroom and we still had some flickering hope that eventually these youngsters might yet obtain a high school diploma which would in some way open the door to expanded job opportunities. But follow-up investigations of those discharged and the difficulty we faced in working out discharge plans led us to look for educational and training approaches that would focus minimally, if at all, on the classroom setting.

Experience with job placement for three boys drove home to us the nature and intensity of their dedication to spending the foreseeable future in their hospital home. Two of the boys didn't even pay lip service to a desire to leave the hospital. Obviously more was needed and this would have to take place sooner after entry into the hospital.

In the fall of 1968 the senior author took the "teacher, work-coach" role on a full-time basis. He was joined by another full-time coach. We selected ten boys and seven girls as candidates for a long-term effort at fostering both social competence

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and a feeling of being an independent responsible individual. These 16 to 18 year olds had been hospitalized for as long as seven years. Their median stay was 23 months in contrast to the approximate six month stay of our average patient. They were severely retarded academically and their mean IQ was 79. They looked at life as simply random forces acting upon them. There was no rational plan in the world they perceived, and events in their lives were seen as being in no way a consequence of their own actions. Fate or powerful others were seen as the determiners of their existence.

Program Design

The program that was designed presented four related kinds of activities.

1. *Practice in independent functioning and social competency*

Our first emphasis was on group discussion and "activity meetings". This included group planning for social activities, engagement in the activity both in the hospital and the community, and discussion meetings aimed at fostering insight into self defeating behaviors. The meeting also provided the opportunity for verbally rein-

obtain. Activities have included preparation of food, grooming, and other specific vocationally related activities such as handling laundry.

3. *Community-based work habit training*

Within a short time we came to realize that our socialization efforts through discussion groups (noted under 1 above) were not productive. The group could not independently generate goal-directed discussions and, as the teacher-counselors entered in more actively, the patients would "parrot" them. Our hopes for meaningful encounter and growth through discussion were shattered, but we did come to recognize the extent to which the patients were ready to endow us with God-like qualities. To some extent, we have attempted to capitalize on this. It was after this failure that our role began evolving from that of counselor to coach.

We adopted the role of coach to encourage team-work and peer-group reinforcement for masculine performance. Looking at our present mode of operation, group cohesiveness is built by the use of "ordeals", i.e. long hikes, rock climbing, overnight camping, and "getting lost" (leaving the boys to their own devices after disorienting them in the woods).

They looked at life as simply random forces acting upon them.

forcing appropriate behavior shown during an activity. We soon moved toward individual "social-task-assignments" e.g. a bus ride alone into town and other more specifically defined activities.

2. *In-hospital training center*

This was aimed primarily at the girls and included improving skills such as manual dexterity and speed as these might come into play in work they might eventually

During this period we attempt to break dependency on adults by forcing the group to work together. But the coaches remain involved in the sense of providing desirable role models. Strenuous farm work, improving camp trails, tearing down buildings, and, finally, group work in a canning factory have provided a progression through more and more demanding and realistic job demands.

4. *Individual on-the-job training*

This has become the final phase of our program, final in the sense that when our adolescents reach this point they are working for and paid by a private employer. This does not imply that our patients must pass through each phase in order to reach this level. What we have added at this

If the supervisor knows he is dealing with a mental patient he may make too many allowances, using kid gloves, only to have to discharge the patient after a short period of employment.

phase is our own involvement, at the patient's side, as trainer. Employers have permitted us to, in this way, help the patient organize the task, e.g. restaurant dishwashing or factory work, and to develop proficiency. Our role as trainer, which we feel is crucial, if not completely innovative, enables us to handle that patient in the manner that we have found to be most effective. We have found that the regular work supervisor initially feels uncertain about the best way of communicating with the employee. If the supervisor knows he is dealing with a mental patient he may make too many allowances, using kid gloves, only to have to discharge the patient after a short period of employment.

Within the past three months the majority of our boys have arrived at this level. First they worked together in a canning factory under the direct supervision of our coach, and at the time of this writing five boys are working in a variety of community jobs under varying amounts of direct supervision from us. With the exception of two boys who are rooming alone separately in the community, our privately employed working group continues to live in the hospital. This is due partly to their ages and also to the lack of compatible living quarters. We see our girls' group as approach-

ing the point where they too can move into community employment.

This chronological and perhaps too neat description of where we are in our efforts is not presented as evidence that we have arrived at the formula for success. There is a tenuousness in the work adjustment of four of the five boys now working privately and we are well aware of the remaining difficulties in overall social functioning. But we do feel that: 1. We have culled out a number of practices and have gained some confidence in others; 2. If we can pick up our clients quickly, within several weeks after hospital admission, we can combat the iatrogenic effects accompanying institutionalization.

Dealing with Chronic Adolescent Patients

As we have learned what techniques were unproductive we have also found a number of approaches that have been effective. Following are several assumptions under which we operate and the approaches we use to implement our aims.

1. *The unconditional imperative*

Our patients are dependent both on the hospital and upon others for leadership. Their dependency and fear regarding independence may well be of greater magnitude than any positive pull exerted by conventional reinforcers. Likewise, conventional punishments, such as isolation in one's room, or deprivations may be quite tolerable to them if the alternative is a step toward independence.

To deal with this massive resistance we make our requests brief and specific and in the form of an "unconditional imperative". We attempt to overwhelm any attempt to resist by shouting down protests and demanding that an action be performed because "That's the way it is in this group". All complaints, individual wishes, or de-

mands for explanation of why something must be done are passed off as being irrelevant. We refuse to respond to the endless variety of tactics patients have developed to avoid performing independently. We are often amazed at the demanding yet intrinsically purposeless activities they will carry out without resistance once the "imperative" ethic permeates the group. Trudging through swamps or climbing steep hills are examples of such ordeals.

The use of the ordeal, noted above, aids in the development and acceptance of the "unconditional imperative". We have found that this can be inculcated into the group so that the members themselves come to exert a kind of control over a recalcitrant. Thus, if one member complains about illness, for example, the others spontaneously laugh as if to indicate that such a statement is incomprehensible if not unthinkable. The group, when responding in this fashion, is more effective than the coach can be. The purpose of the unconditional imperative is to convince the patient that there is no alternative available to carrying out the proposed assignment, and, in a sense, we keep him off balance in our effort to accomplish this.

Refusing to even hear complaints and constant shifting of attention to positive aspects of a job seem to have good results. The patient at times becomes so confused by the torrent of praise and push that he forgets his complaint and charges back to the job with new enthusiasm.

No attempt is made to be logical or to permit the patient a choice about returning to work. We have become convinced that many of the patients never hear nor understand the content of what is being explained to them. What is said isn't as important as the emotional tone used to communicate it. It is most important here to talk encouragingly, in good humor, and fast, all

the while pushing the patient back to work. Suggestion, then, is in a sense a step beyond the cruder unconditional imperative. In this the coach can maintain a pleasant manner.

2. Suggestion

Many of the patients in the group seem especially susceptible to suggestion. Good performance can often be maintained by periodically telling the patient how much he, the patient, likes what he is doing. Short pep talks take the place of discussions.

3. Regular and close communication with employers

We feel that weekly checking with employers on a patient's work is, by itself, ineffective. The work supervisor must be encouraged to convey freely what is actually happening on the job, and this has a better chance of taking place if the coach has already indicated that he is intimately familiar with all of the client's tactics. The work supervisor must obtain a grasp of the coach's goal so that he neither coddles the "mental patient" only to discharge him at the end of the week, nor rejects him outright.

The opportunity, where possible, for the coach to work with and directly supervise the patient for at least a brief period is extremely useful. Knowing the patient's work shortcomings, he can break down the units of the job to segments meaningful to the patient while still carrying the unconditional imperative to the work setting.

Some Necessary Conditions for Moving the Hard to Move

We have been fortunate in having the interest and cooperation of several indispensable resources in dealing with this very resistant group.

First, we have found a number of employers in the community who are willing

not only to give our patients a chance but also to permit us to spend time right at the work station with the patient. We have been successful in developing a relationship with several employers to the point where we can communicate our goals and look to them to follow through.

The vocational rehabilitation counselor has made his resources available mainly in the form of funds for emergency living expenses and paying patients for community-based jobs such as the forestry work noted above. The counselor has also at times aided in the coaching, familiarizing himself with the jobs and doing the training at the work station.

In the above techniques we are admittedly bending the client to our will. There is questionable personal growth at the moment of his acquiescing, but he is accomplishing the task demanded and we see this as being of paramount importance. And there is a paradoxical situation inherent in this; with some success in a job the client loses some of his dependence and in turn becomes less easy to manipulate. Thus, the time should come when the client begins to view himself as having some competence for self determination, and he might then realize that he needn't permit himself to be "conned" into working. We have found that at that point the more common types of reinforcements can be brought into play.

Good performance can often be maintained by telling the patient how much he, the patient, likes what he is doing.

Community agencies such as Goodwill Industries have likewise permitted us to temporarily become part of their supervisory team. We have found that with patients with relatively good occupational potential the workshop assignment should be rather brief. As with stay in the hospital we feel a strong need to convey to patients

the idea that their assignment is time limited, that they will soon move out to private employment.

We feel we have been successful in orienting ward personnel to our goals and they have been willing to follow through with our approaches. In many cases they had been witness to the failure of traditional educational, treatment, and job placement efforts and have been as enthusiastic as we have been.

Conclusions

We have described our approaches with a group of teenagers for whom the prognosis at best is guarded. In most cases their families have been non-existent or have not been a useful resource, and these patients have experienced little but failure prior to entering the hospital. Our hope has been to find ways to avoid protracted hospitalization and to nudge our patients into at least a marginal kind of existence in the community. At this date 22 young people have been included in the program. The five working in the community at this time are boys. The girls are considerably younger and therefore most of them are not able to be placed yet. The fact that our coaches are male and that much of our activity is male oriented is probably also a factor in this.

We have yet to face the question of the duration of our contact with the patients after they leave the hospital, though we know that some kind of follow-up services are necessary. We can look to difficulties in social relations and in managing many facets of their personal lives. But at this point we feel some gratification with our ability to bring some feeling of accomplishment into their lives. Finally, as we continue, we are seeking to identify our candidates very early in their hospital stay and to begin our program before their fears of life in the community grow beyond reason.

Samuel Tenenbaum, Ph.D.

School Grades and Group Therapy

Nine students who were on academic probation attended group therapy sessions once a week during one semester. Their grades improved dramatically.

There are no lazy people. There are frightened people, anxious people, bored people who have found no meaning in life and hence no meaning in the activities necessary for life. And there are people who have unrealistic notions of who they are and what they are. They, too, are crippled for realistic living. As for students, what keeps them from their work for the most part is fear of failure, terrible self-demands, low self esteem, inability—intellectually or emotionally—to cope with the tasks set before them. In our culture, students find it more acceptable and more respectable to plead disinterest and laziness, rather than lack of capacity and intelligence, and this is the way most students and parents prefer to explain failure.

In the main, young people who have school problems are immobilized by their fears. When a child is doing poorly at school, teachers are wont to attribute it to indolence and laziness; rarely to his fears, his hang ups or his great desire to please his parents, all of which may be debilitating and self-defeating.

There were a number of education major students at Long Island University who

had been on probation semester after semester. Before expelling them, the then Dean of the Division of Education, and the adviser of the Educational Counseling Service thought that as a last chance, they ought to be given the opportunity of having a group therapy experience. I was asked if I would like to take over the group and I accepted, having advocated such group experiences, not only for students in academic difficulties, but for all our students for many years.

About 15 students were originally assigned to the group. Six came once or twice and never came back. I was left with a group of nine, six of whom came regularly and three irregularly.

In my private practice I seldom experience a cancellation. The thought that students who did not pay a fee would reject the chance for a therapeutic experience was something I could not contemplate without of severe blow to my self-esteem. But this was my own problem and I never communicated this to the group. I held firmly to the belief (and I still do) that it was for each student to decide whether he wanted to attend or not; and if a member stayed away, I interpreted it to mean that he wasn't profiting and it was, then, a reflection on me and not on him. Every absence made me feel very uneasy and guilty.

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From the outset I never asked students to work or study harder, for I assumed that the thought had occurred to them; or if not, someone else had told them of the need. Never once did I bring up the matter of grades unless they did. I did try to listen, to be sensitive to them as they expressed their grief, worry and often despair. As I listened I often wished that faculty members could be present and hear these anguished communications, so that they could understand what a grade means.

Although students could attend at most ten sessions of one hour and a quarter, not one of the nine failed a single course, not only during the semester in which they participated in the group experience but also in the semester that followed. Where hitherto their records had been filled with Fs, Ds and Cs, after their group experience there were several As, B+s, Bs and C+s.

Prior to their group experience, grades C+ and higher for these students came to 24.7%; after the group experience it rose sharply to 65.0%. Before the group experience, grade C and below came to 76.3%; after, it was 34.5%. In all their previous school experience, these students had failed 10.4% of their courses. After their group experience, they did not experience a single failure or F grade for the entire academic year. As for the D grade, there was a sharp drop, from 31.2% to 9.6%. Even for the gentlemanly pass, the C grade, there was also a drop from 28.9% before to 22.5% after. These percentage deficits in C and lower grades were made up by the sharply upward movement to grades above C after the students became involved with the group.

In their prior years at Long Island, (two had attended the university six semesters and seven, four semesters), these students made altogether one A, which was 0.5% of all their grades. In the semester concurrent with and the semester following

their group experience, they made eight As, representing 8.6% of all their grades. Before their group experience, their B+ grades came to 2.3%, after, 10.6%; their B grades before, 9.8%, after, 25.8%; C+ 10.4% before, after 17.1%. After the group experience, their grades rose markedly from the lower end to the higher end of the grading scale.

During the semester of the group meetings, I asked the students to write brief reactions to each session and several of those are quoted here.

At the start, they found talking difficult; and their communication was random and

Although they were doing unsatisfactory school work, it appears that every member of the group had the requisite intelligence to perform the academic tasks set before them.

desultory. They could not understand how plain, ordinary talk could help them with their grades. All were reluctant to reveal their probationary status and their silences were long and severe.

These are two typical early reactions:

I noticed today that we, as a group, have a lot in common as to why we are on probation, but that our fears of being with strangers prevent our really coming out with the true facts of our problem. . . . I am sure if someone starts, others will follow.

I don't see how anyone can really be helped. . . . and there are many things I won't say because there are other people in the room.

One member took to the process immediately:

After leaving the first session I felt as if a great burden was lifted from my shoulders

"One thing we have in common is meddling parents."

because for the first time in my life I could speak freely of the personal problems which I have been faced with in the last few years. . . . For the first time in a long while I didn't feel any anxiety about being in a classroom.

Mostly, however, they did not know how to articulate feelings; and they resented having to make the effort. This was a hard stage for them and for me. Wrote one member: *"If it seems that I don't participate as much as the others, it's just that I get very upset telling my problems. . . . I hope at future meetings it won't bother me as much to tell my problems."*

Gradually, they talked less and less about school and grades and sought each other out for support and comfort. Bound as they were by a common grief—the pain and the hurt and the shame of their probationary status—the group slowly began to jell and assume a close, in-group quality.

I was happy during this session because I felt that we are learning different facets of each other's personalities. I felt in the past our lives started and ended with classes and that we had no other lives outside of school. During the hour we spoke of ourselves socially.

It is amazing to what extent parents figure as a disturbing influence to the members of the group; how, instead of helping them, they fill them with disturbing emotions, so that the tasks in connection with school do not become a personal student involvement but a way to win parental approval and an honorable and respected position in the family. For these students, school represents nothing but a vehicle to get grades sufficiently high so that parents

will think well of them. For the openly rebellious, a struggle may develop between student and parents. The parents will badger their offspring: "Have you studied enough?" "What grades did you get on your examination?" "Have you done your homework?" The educational experience becomes subsidiary to parental needs and demands. In such instances, there may be acrimony and bitterness and sometimes despair, not because of what goes on at school and what school represents, but at what goes on at home. Here are typical student reactions:

I was very glad to see that I'm not the only one with "mother problems."

One thing we have in common is meddling parents. I am not saying this is the cause of our probation status, but it may very well be one of the causes.

The parents took the responsibility of the school task away from their children. Further, no matter how they rebelled and how bitter the acrimony, these students took it for granted that their parents were right and that they were worthless. Although this did not make them better able to cope with the school situation, it did make them feel guilty and inadequate. These feelings, in my judgment, only accentuated students' anxieties and made them less able to meet school demands. In the group sessions, students began to perceive how parents figured in the school situation, and to understand better the nature of their parental relationships. One student writes:

I realize that my mother will never be pleased. That is something I never realized. I'm sure this . . . will help me . . .

now and in the future. For if I keep listening to her, I may find I'm living for her rather than for me.

Although the matter of grades and probation was always present, the discussions soon went far afield of grades. They included their whole persons; how they struggled, how they failed, also, how they triumphed. In my opinion, this proved to be the most valuable part of the experience since it helped them gain realistic insights into their own difficulties and their own persons.

I feel that much was accomplished in (our last session) in that the meeting really brought me to thinking why I got marks as I did . . . The family situations described (by others) were somewhat like my own so I was helped in that area as well. . . . Though I don't fully understand why I've been so erratic in my work, I know that it has been at least 90% of my own doing and I aim to better myself.

In the final stage, they were a united group, working in unison, understanding one another, better aware of their own feelings and their own problems, more realistic about what needed to be done. Below is one reaction articulating this new awareness of self, these new insights and new resolutions.

I truly believe that our open-mindedness about our individual problems has helped us to achieve our success. If we can continue to verbalize about ourselves, then surely we can allay our fears about school. . . . Of course, we have to work and study, but I feel that by talking, half the battle to get off and stay off probation is won.

I asked for a final reaction as to how they viewed their experience and requested

that they send me their final grades. These were mailed to me after their final examinations and long after the group had broken up. I wish there was sufficient space to quote these communications verbatim.

One in particular sums up the many reactions:

. . . it was a very good feeling to know that there were others in the same category as myself; and that there was a person, such as yourself, who seemed to take an honest interest in each individual. I feel that now that I am off probation, I will stay off.

Discussion

At first the group members did not know how to talk and were reluctant to talk. Each member of the group thought that "being on probation" was unique to him and each carried this burden for the most part secretly and in shame. When they discovered that all in the group were on probation, it had an exciting, liberating effect. Eventually, their common problem served as a bond and a tie to unite them.

I want to emphasize that in none of the sessions did I bring up the matter of their grades; in no instance did I make them feel that I wanted them to get higher grades, or that I was in any way involved with their grades.

Although the group members' probationary status was always present, once they revealed themselves as persons, they discussed grades from a deeper and more significant point of view. Grades became linked with their anxieties, their hopes, their weaknesses, their failures, their parents, etc., etc.

In the group, the members received regard, encouragement, support, affection. Their ego strength increased, their self-respect rose, and as one of the outcomes,

I believe, they were able to confront their school situation in a healthier and more intelligent way. They were able to view themselves and their problems more insightfully, more realistically. One spoke of anxieties so great that she could scarcely live through an examination. Others spoke of frightening instructors who marked you down for anything and everything so one couldn't think. My heart went out to these unfortunates, as they tried so hard to make themselves small and inconspicuous in class, fearful of being called on. Others spoke of personal situations which they faced that kept them so distraught that they were immobilized from doing anything. "I got started studying and then my mother got after me and we had the worst fight in a month and I couldn't study, and she said I was no good and I would never be good." The tears rolled down her eyes. "I couldn't study . . . and I couldn't sleep that night."

The group experience made the members more articulate. Before they were silent in class—outsiders. As they became more aware of their feelings and better able to articulate them, several managed to develop more personal relationships with some of their instructors and, best of all, a number became more active as class participants. These began to feel like persons and act as persons, not nonentities.

When I discovered that the group members made even higher grades in the following semester than they did while they were undergoing the group experience, I was puzzled until the thought occurred to me that they did not have the full force of whatever is therapeutic in a group until the following semester; and that this could account for the difference.

Although they were doing unsatisfactory

school work, it appears that every member of the group had the requisite intelligence to perform the academic tasks set before them. In fact, several became, after the group experience, not only successfully functioning students but superior students. The question arises: On what exactly does academic success and failure hinge? Are grades a symptom of the whole functioning person, who and what he is, and not primarily a matter of intelligence which hitherto was regarded as the main and only component. If yes, what are these other factors? Further, if these students had not undergone the group experience, what would have happened to them? How would their lives have been changed? This is a matter not to be taken lightly. In our society, college graduation is the union card for valuable rights and prerequisites, vocational, social and even marital. Would they have righted themselves on their own or would they have been expelled as academic failures with all its inherent emotional and psychological trauma, very often lifelong.

This is not a statistical study. It is rather an account of nine persons, each one apart and separate, who participated in a group experience. Although we can conjecture, I do not believe that at this stage we know exactly what happens to the members in a group of this kind; how a group affects each in it; and how each in it affects the group.

The hope is that with time, with further study and inquiry, the process will be better understood and therefore better controlled, and hence, we will be more able to replicate outcomes. Even with our present knowledge, we have every reason to believe that when a group works, it can be highly salubrious and therapeutic, in ways which we have not nearly plumbed.

Alfred M. Wellner, Ph.D.

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Program Evaluation: A Proposed Model for Mental Health Services

The authors propose a model of evaluation that will help mental health program planners and directors to conceptualize the issues and components of a program evaluation system. It includes three levels—Outcome Effectiveness, Strategy and Systems Overload—that can be examined to provide a clear picture of the service.

This paper is an attempt to provide a basic model for the systematic collection of relevant information to permit personnel to evaluate their programs and to, thereby, modify the programs to achieve maximum output from available resources. There is a need for an evaluation model that serves to stimulate the application of evaluative procedures for mental health services and function as a general guide to concepts in evaluation for personnel with relatively limited experience in this area. Goals in the field of mental health have been primarily "non-operational" in the sense used by March and Simon⁷. That is, the means of testing action have

not been perceived to be related to a particular goal or criterion with possible alternative courses of action.

There have been recently, a number of reports and papers on program evaluation in mental health.^{1, 3, 5, 6} Suchman's⁸ text is an excellent work on the principles underlying evaluative research in service and social action programs. The survey of a selected group of community mental health centers, however, indicates that little or no evaluation was being conducted at that time.² Few of these reports have given systematic attention to the planning strategies and dimensions of choice which structure the complexity of the evaluative process.

The Model

This proposed model for program evaluation is based on the premise that all programs can be systematically reviewed for

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the purposes of: a) determining the characteristics of services provided or the process of service delivery; and b) the degree to which the stated objectives of the service are being met. The model also assumes that these are two separate and distinct evaluative processes. The model also supports the principle that evaluation should provide information on why a program did not meet a stated objective or goal, and not just whether it did or not.⁹

In addition, this evaluation model recognizes the need to systematically identify service and administrative demands which are not being met. That is, it seems essential to also identify actual demands as well as theoretical needs of the facility and its personnel.

Level I—Outcome Effectiveness

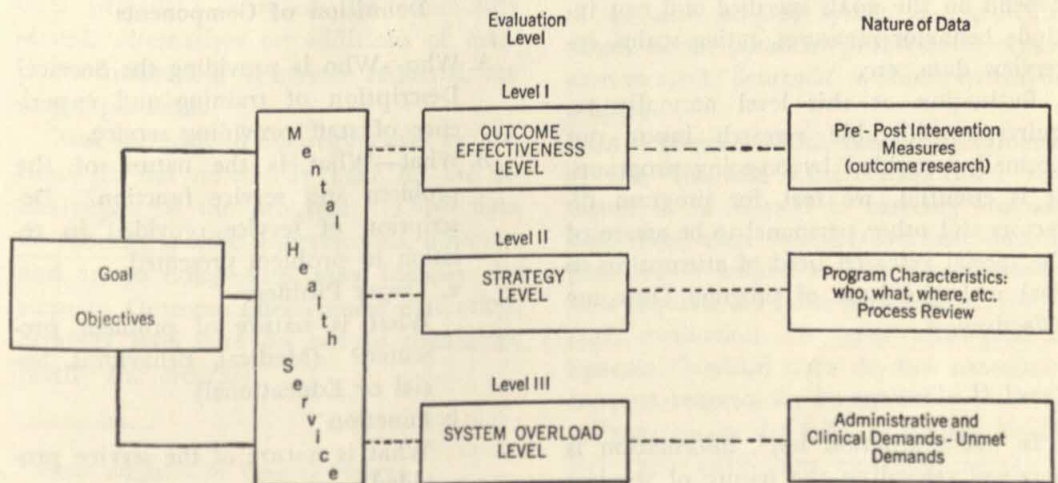
This level of evaluation tests the assumption that intervention changes the

consumer or target population in the directions specified. The question answered by the level is, "Has the program been effective in attaining the goals specified?"

These goals must be precise and measurable. The intervention may be considered as "treatment" or "services." In order to clearly establish the relationship between the intervention and the goal, pre-intervention measures are necessary. Post-intervention measures are also necessary if careful and meaningful comparisons are to be made. In addition, pre- and post intervention measures must be taken on potential consumers of service who do not receive the intervening treatment (a control group).

Changes in desired directions on post intervention measures, if they occur, are not sufficient tests of effectiveness. It is possible that these same changes could result from just the passage of time. It is therefore necessary to include comparisons with groups receiving no intervention.

THREE LEVEL EVALUATION MODEL



The basic effectiveness evaluation level includes the following essential elements:

- a. identification of precise and measurable goals
- b. selection of potential consumers (target groups)
- c. obtainment of pre-intervention measures
- d. application of intervention to part of potential consumer group
- e. obtainment of post-intervention measures
- f. comparison of results:
 1. pre- and post comparison
 2. intervention and non intervention comparison

Further refinements, yielding more precise information, may be introduced. For example, rather than simply obtaining pre- and post intervention measures, one could obtain measures at various stages of intervention (e.g. 2nd, 10th, 16th session) and again at the termination of the intervention and at intervals thereafter (e.g. 6 mos., 1 yr., 5 yrs.). These refinements require considerable effort and manpower committed to evaluation or programs. The instrument selected for measurement will depend on the goals specified and can include behavior measures, rating scales, interview data, etc.

Evaluation at this level normally requires considerable research input not normally provided by on-going programs. It is essential, we feel, for program directors and other personnel to be aware of the special research need of attempting to deal with the issue of program Outcome Effectiveness.

Level II—Strategy

In this evaluation level, information is obtained regarding the nature of services

provided. Basically, it answers the question of who is doing what to whom, when and where.⁴ Information derived from this level gives a clear analysis of how staff is using its time and the characteristics and process of the services provided.

Most programs routinely collect information on the characteristics of services provided. Budget requests are usually accompanied by data which reflect some aspects of services rendered and the nature of the personnel who are providing the services. The following outline provides for the identification of Level II components and for facilitating analyses and comparisons of the major groupings. The specifics under each grouping will have to be determined by the nature of the program. It would be very difficult if not impossible to try to identify each and every possible category under each heading. (For example, under the "who" component we have listed community agent as a subgroup.) There are too many different kinds of community agents (police, welfare workers, ministers, etc.) for a complete listing. Each program can identify the groupings appropriate to its services.

Definition of Components

- A. Who—Who is providing the Service? Description of training and experience of staff providing service.
- B. What—What is the nature of the problem and service function? Description of service provided in relation to problem presented.
 - a. Target Problem

What is nature of problem presented? (Medical, Behavioral, Social or Educational)
 - b. Function

What is nature of the service provided?

- C. To Whom—Who is the recipient of the service? What is the target or consumer group?
- D. When—What time period is the service provided? What time of day or what time of stress or when in consumer's life experience is service provided?
- E. Where—Where is the service provided?
 - 1. A mental health facility (hospital, clinic)
 - 2. An existing community agency (welfare, church, etc.)
 - 3. Turf*—where the crisis or problem occurs (e.g. home job, location, street, etc.)

As can clearly be seen, information gathered at this level will give a good overview of the nature of services provided, the delivery of those services, and their extent. It will also delineate the professional functions and the target problems with which the program is dealing.

Describing functions according to the Strategy Level gives a clear account of the options exercised in the program. These data provide a view of the community served, alternatives or additions of manpower utilization, of service rendered, the target problems.

Data included in Strategy Level evaluations do not necessarily bear on the effectiveness of the program. These data do identify specific interventions, however, and in so doing they may identify the steps in Outcome Effectiveness evaluation. Strategy level data do not in themselves justify the program.

Systems Level III—Systems Overload

In this level of evaluation, the issues regarding the demands on the services, both administrative and clinical, are identified. It is essential to maintain on-going records if the services staff is unable to provide them because of personnel or budgetary limitations. Backlog of dictation, unmet speaking engagements, waiting lists for clinic services, staff inability to accept invitations to join local committees, etc., all reflect an overload of the system and should be identified. This level data reflect what could be done if additional services were available or a different utilization of services were designed.

This level of evaluation, like the Strategy Level, is one which is often associated with budgetary request justifications. It provides data on which many programs expand in response to demand—sometimes (too often) without the benefit of an Outcome Effectiveness study. That is, demands create overloads on the system which responds by expanding itself. It may be that if the system were evaluated and possibly re-structured without additions, the demand could be met more effectively and efficiently. The development and expansion of the state hospital system is a good example of the potential problems of expansion to meet "demands" without systematic analyses.

In a program which has been evaluated at the Outcome Effectiveness level and found to be effective in meeting program objectives, such System Overload data is particularly helpful in support of expansion requests. In those programs where no such evaluation has been accomplished, Systems Overload data do not necessarily support requests for expansion.

Programs in the field of mental health have very rarely been evaluated at any of

* Term suggested by Gregory Helweg.

the above three levels. Research studies in the literature are primarily of the Effectiveness Levels of very specific intervening activities. The statistics that are usually collected in mental health services regarding number of patients seen, (Psychiatric Case Register, for example) type of treatment provided, are primarily of the Strategy Level and are usually quite restrictive in terms of content. Very rarely does this information lead a program director to alter his program or to be able to refine or redefine it. The Systems Overload Level is the one with which administrative personnel have been primarily concerned for budget requests, without, however, the accompanying Outcome Effectiveness level data.

Summary

This model is proposed to assist program planners and directors in the field of mental health to conceptualize the issues and components of a program evaluation system. The Strategy Level can be used by program developers to assure the inclusion of all components of a delivery system. It can also be used as a preliminary guide to the kinds of data that should be collected in order to have base-line information on the nature of services.

The combination of the three evaluation levels provides a concise and yet complete picture of the services, their problems, and their characteristics. It should be pointed out that programs which attempt to use an Outcome Effectiveness Level evaluation model, will require individuals assigned to data collection, and research efforts. To realistically answer the question of how effective a program has been, measures will have to be taken before and after the introduction of that program. Indeed, it would

be advisable for such Outcome Level evaluations to also include a comparable target group for which no intervention is provided which can be compared with the target group for which the service has been designed. This would provide an even more rigorous comparison and analysis of the effect of the service intervention.

The Systems Overload Level should assist directors of mental health services to become aware of the need to classify and categorize the kinds of demands made upon the services which are not reflected in the usual statistics and patient records.

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Kenneth Z. Altshuler, M.D.

John D. Rainer, M.D.

Observations on psychiatric services for the deaf

Total deafness from birth or early childhood is marked by a severe communication barrier and great difficulty in learning verbal language. These deficits often complicate neurotic or psychotic symptoms which may exist. The authors describe their experiences in working in a comprehensive program of services to the deaf mentally ill. Experience has shown that some individual therapy with group therapy and pharmacotherapy are effective. In addition, consultation, treatment and group meetings with deaf students and their parents serve the purpose of prevention and early detection of emotional difficulty.

Being deaf from birth or early life means that audition is not available as an avenue of communication with the world outside. The most obvious resultant difficulty is the failure to learn verbal language without years of special schooling and arduous, unrelenting effort. So demanding is the task that only about one quarter of those with early total deafness ever develop really usable speech—the majority relying primarily on manual communication, the language of signs and finger spelling. While

there had been several studies attempting to discern and define the psychological sequelae of deafness,^{3, 4, 5} psychiatric interest in this group emerged only in 1955, when New York State established its first Mental Health Project for the Deaf. Over the next 15 years, the program evolved so that it now provides a complete set of psychiatric services.

Early findings and current organization have been reported elsewhere,^{1, 7, 8} and the present paper will focus only on a discussion of the techniques found applicable to work with the deaf, some of the indications for them, and the results achievable when a balanced program is available. By way

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of general introduction it should be said that for effective psychiatric work with most deaf patients, a knowledge of manual language is the *sine qua non*.*

Individual therapy continues to be the primary weapon in the psychiatrist's armamentarium. Psychoanalytic work, modified of course to allow for face-to-face communication, has been useful in only an occasional case.

The more widely applicable approach has been a combination of supportive treatment with the achievement of limited insight. Many patients are unsophisticated or have little motivation for the struggle required to make a firm internal change. They approach the doctor on a magic-craving level, hoping he will convert the environment or somehow do away with the problems.⁶ Supportive therapy allows one to make use of this tendency rather than to analyze it. Direct guidance and counsel are the tools, and the parentified relationship with the therapist is the vehicle. This approach is useful with the more psychiatrically disturbed outpatients and with the hospitalized deaf patient, many of whom have severely underdeveloped communication skills. Role playing and instruction in social and job relationships and expectations are often required, as is also the actual teaching of language—especially to hospitalized patients.** Changes in behavior initiated at the therapist's direction will often lead to the patient's becoming more comfortable and thus pave the way for him to begin to see what it was in his previous behavior that had

elicited unpleasant situations. This is the limited insight aimed for, since deaf patients are often strikingly unaware of the impact of their behavior on others.² With the recognition that what they do has an effect on other people a whole new vista of human relationships may be unveiled.

Group therapy has also been adapted for work with our deaf patients. We began such treatment with the first several patients available (females) when the inpatient unit opened in April 1963. After three months with this group of ladies it was apparent that, despite some movement, little was happening. When the first male patients arrived and were included in the group, things perked up noticeably—grooming improved in both sexes, and motivated behavior appeared more clearly: rivalry, sexual interest, and active withdrawal, for example. From this we decided that the groups should have members of both sexes.

Later we tried an experiment in self government, to foster independence and a sense of responsibility. At first patients motivated each other to improve their communication abilities or ward performance, and made recommendations for ward improvements or even with regard to minor self-disciplinary measures. Then a young psychopath bullied his way to the presidency, converted the democracy to a dictatorship, and held kangaroo court on the defiant. We suspended the government and learned that group work with hospitalized deaf patients required firm, though flexible leadership.

As the group experience continued to unfold it was also clear that the patients required consistent encouragement to evaluate each other's statements and their own reactions to one another. It was also noted that, in addition to being deaf and mentally ill, many of the patients were in-

* The staff of New York State's project—aides, nurses, social worker, psychologist and physicians—are conversant in manual language, and weekly, continuing classes have been held since the first project was activated.

** A full-time teacher of the deaf is part of the cadre in New York's inpatient unit.

credibly naïve and ill informed. Long hours were necessarily used for just conveying information or a concept: an employer's expectations on a job, for example, or why honesty or restraint is generally preferable to the self-willed grab. This further emphasized the need for flexible leadership under which the group could be used as a forum for general education as well as more directed psychotherapy.

We also adopted the use of a patient as group leader or co-therapist for one of the three sessions a week that the groups met. This was done in a further attempt to foster leadership, self respect, and reality-oriented critical thinking, and to structure the group toward mutual involvement and away from nagging concrete questions to the therapist about "When do I leave the hospital?" and "When do I get more (hospital) privileges?"

Following these principles, our experience has indicated that group therapy for the psychotic deaf is well suited to serve as a vehicle for broadening general experience and for learning to function in what

meetings with adolescent students are also conducted.

Results of the groups thus far suggest that they are achieving their purposes. Complaints about the school and its programs and regulations have served as a springboard to develop ideas about personal ambitions and responsibilities. In a number of students there has been a notable shift from self-willed rebelliousness to better cooperation, longer range planning, and a sense of themselves as responsible, maturing young adults.

Groups of parents meet as well with the psychiatrist in charge of this part of the program. One group is composed of parents of young deaf children (five to eight years of age) and another of parents of older, adolescent students. The parents of younger children have responded hungrily to the group opportunity. Parents of older children, while evidencing great need for counseling, have been more difficult to involve in the group sessions. Having raised their children to the ages of 16 or

When the first male patients arrived and were included in the group, things perked up noticeably . . .

is a society in microcosm. It has been found to be a valuable adjunct to the individual therapy, medication, social work services and other ancillary programs of treatment available at the unit.

The most recent additions to our program of psychiatric services for the deaf are a preventive effort at a school and a rehabilitation program extending from the hospital into the community. In the school we provide individual consultation and treatment, and discuss the findings with teachers and cottage parents so as to assist the student to function and to succeed, and enable him to mature healthfully. Group

17, they apparently have developed comfortable ways of insulating themselves against their own conflicting feelings. As a result they have a vested interest in seeing themselves as "good" parents, and they tend to blame any difficulties on the school or other social influences while rationalizing their own distorted ideas as being well founded in reality.

A final word about the rehabilitation aspect of the psychiatric program. To help patients bridge the gap from the structured hospital to the community we have developed a working relationship with Fountain House, a halfway house in New York

City. The House program calls for living accommodations in separate, though supervised, apartments and supervised work ranging from office duties to participation in a thrift shop, a car wash, and industrial activities. A number of our patients with-

It is worth emphasizing that at eleven to thirteen dollars per hospital day, each patient-year averted saves the state government at least \$4,000.

out families or roots have been helped into community living through this program. Our tie-in with the Division of Vocational Rehabilitation allows us to open cases and make arrangements early while patients are still on the ward, so that training programs are available soon after discharge and may be continued from a patient's own home base or the halfway house living quarters.

At this moment we cannot predict with any certainty the results of a preventive program. If measurable at all, its tangible effects will only be felt after several years. While evaluation of psychiatric results poses a host of problems generally, a reasonably clear measure is attainable with the inpatient unit and rehabilitation program. Here each patient serves as his own control, and his previous history, coupled with a knowledge of what hospital treatment may usually offer, can allow some basis for prediction. We obtained such an independent prognosis for all patients present in the hospital unit during the first two years that the rehabilitation program was in effect. A psychiatrist with long years of state hospital experience reviewed each patient's record and made his prediction according to the following categories:

Poor—patient will probably remain chronically hospitalized for life.

Guarded—no real improvement expected, may be out of the hospital briefly, but will probably be in the hospital more than out for the balance of his life.

Fair—some improvement expected, probably will be out of the hospital more than in, although exacerbations of illness are expected.

Good—chance of permanent rehabilitation with no or occasional brief returns to the hospital.

After two years of operation we charted the following results. Of the 47 patients expected to remain hospitalized for life, 18 achieved good or fair results. Similarly for 14 of the 16 patients expected to be out of the hospital briefly at best, the results were also good or fair. All with current results of "good" and all but three in the "fair" category have been discharged from the hospital. Of those with original prognoses in the "poor" category, seven are now working, three are in training programs, and three are effective homemakers; the comparable figures for the "guarded" group are five working, one in training, and four homemaking. It is worth emphasizing that at eleven to thirteen dollars per hospital day, each patient-year averted saves the state government at least \$4000. Less tangible but just as gratifying are the personal benefits derived by a person who can leave the hospital to contribute productively to his own support and fulfillment.

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On The Highway

Enemy earth,
Alien earth,
Changing to
Friendly earth.
Flowing with the guard-
Rail lights,
I am in an underwater
Ecstasy of
Light and smoothness.
Flow on,
Drive on,
I may
Come to dry land
Yet,
Touching friendly
Earth,
Solid earth,
Wonderland earth,
And no longer
Needing
The fantastic waterways
Of my dreamings.

—Annie Wu

Phyllis Rolfe Silverman, Ph.D.

The Widow as a Caregiver in a Program of Preventive Intervention with Other Widows

"I know what it is like. Let me help you."

The author discusses the use of a self help group in preventive intervention. In this case, a group of widows reach out to recently widowed women and offer support in helping them adjust to their new life.

One of the primary problems programs of prevention face is how to seek out people who have not asked for help. There is the question of who is the appropriate caregiver for such a population?³ The Laboratory of Community Psychiatry confronted this dilemma when it tried to develop a program that would prevent emotional illness in a population of bereaved people. In this instance the target population with the high risk of developing serious emotional distress consisted of younger widowed people. A caregiving group had to be defined that would be acceptable to them. This paper describes the caregiving group chosen, their special qualifications as interveners, and discusses the kind of intervention they provide.

The caregiving group consists of other

widows who have recovered from their bereavement. It was hypothesized that if another widow reached out to the new widow she would be accepted as a friend because she was someone who understood since she had been there herself.² Does experience bear out this notion that the recovered widow is an appropriate and accepted helper? The material that follows presents data which provide some answers to this question.

The Widow to Widow Program

The Widow to Widow Program, as this demonstration in preventive intervention is known, has been in operation for three years. Five widows have reached out to over 400 new widows under the age of 60 in this time.⁴

The widow caregivers, called aides henceforth to distinguish them from the widow recipients, all live in or near the community

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they serve. They have all been widowed about three years, are for the most part in their mid-forties, and have no more than a high school education. While their husbands were alive, they devoted themselves to raising their children and keeping house. Two of them did help their husbands in his business. After his death they all had to think of supplementing their income, which came largely from social security and pensions.

Each of the aides had become involved in community activities subsequent to their becoming widows. It was through our contact with these community organizations that we were able to recruit them. Until now they had never thought of earning their living helping people in this way. All of them could talk about their bereavement, the very difficult time they had and the current problems being widowed still created for them. They had only one reservation about the program as it was described to them. They wanted to be sure that service, not research, was the main purpose of what they would be doing.

In order to assure that their experience as widows would be utilized to the maximum no attempt has been made to supervise their work. At weekly group meetings people they visit are discussed, and they use each other as well as myself for consultation about what they have done and about how they might proceed. Most frequently they chart an independent course of action which seems right for them and the new widow they have visited.

They quickly corrected our notion that within one year, or less, a widow has recovered from her bereavement. They feel that although by then she *may* be over the acute stage of her grief, she is not recovered, and may even be depressed by her growing awareness of what the loss means. They say a widow never recovers but rather learns to

adjust to the situation. They thought this took about two years to accomplish. It involves an ability to repattern her life without a husband, to find new friends, new interests, and sometimes a new career. It also means learning to live with loneliness.

Initial Reaching Out and Service Offered

How is their experience translated into their work? Their first task is to establish their credentials as an appropriate caregiver; that is, as someone the widow will accept and see as potentially helpful. The new widow first learns that the aide, too, is a widow in the letter of introduction she receives. The stationery has the names of the three religious groups sponsoring the program on it.* In the letter the aide tells the new widow that she will visit at a given time on a given day. She gives her home phone number and invites the widow to call if for any reason she does not want the aide to visit.

They wanted to be sure that service, not research, was the main purpose of what they would be doing.

The aides do not feel that a visit before three weeks would be useful to a new widow. At the moment of acute bereavement they do not feel that a new widow can identify with another widow, because she still thinks of herself as a married woman.

Several things influence the widows' response to this letter. One is their willingness and readiness to consider that they are

*The program is sponsored by the Archdiocesan Council of Catholic Women, the Mt. Bowdoin YM and YWCA and Temple Beth Hillel. These are community based agencies traditionally involved at the time of a death in the family.

now widowed. Some women thought this was a "terrible thing to call me" and threw the letter away.* Others thought they were "already on a mailing list, now what do these people want?" Still others were impressed with the fact that someone cared, and were reassured by the names of the religious organizations on the letterhead. Some of their reactions were colored by who else was available to talk to.** Some women, therefore, called and told the aide not to come; others chose to let her visit because they lacked the energy to call and refuse

the widow what benefits she is entitled to and how to be sure of getting them. One widow saw this discussion about money as an:

"affirmation of life. It makes you think about what is needed to go on living and reminded me that that's what I have to do."

The aide's willingness to answer questions about her own widowhood seems to give the widow permission to unburden herself.

Many women see widowhood as a social stigma.

the visit. Some simply weren't home when she arrived, but most looked forward to the visit. Many widows subsequently became involved with the program although their initial response to the aides' offer to visit was negative.

Once they sensed there was no ulterior motive in the aides' interest, the fact of the aides' widowhood was the important thing that made it possible for them to become involved. The aide mentions it in her letter but it always comes up early in the actual encounter, either in a face to face visit or on the telephone.

The fact of common widowhood is often discussed through the aides' attempt to clarify how the widow is managing financially. They talk about social security, VA pensions, and the like, and the aide will describe her own experience and clarify for

Sharing Common Problems

The fact of the aide's widowhood seems to make it easier for the new widow to accept her, to talk to her, to ask for advice on problems related to her own widowhood, and to feel as if she can still be part of the mainstream of life—that is, she is not so alone and the only one to whom this could happen. Another widow said:

"Since you are a widow too, when you said you understand I knew you meant it and that was so important. I can't stand sympathy and that's all anyone else could give me."

Pride and an unrealistic wish to be independent seem to get in the way of a relationship between widow and non-widows. The new widow finds the latter's efforts to be helpful clumsy. Often they find themselves providing reassurance rather than being reassured. This does not happen with the aide. The aide is using her own experience as a human being and as a widow to guide her in her encounter with the new widow; she appreciates the real need that exists but never takes the widow's initiative

* This may be why organizations of widowers and widows chose names such as NAIM Conference of Chicago and THEO (They Help Others) in Pittsburgh.

** Many felt that their family and friends sufficed for their current need only to come to an awareness later on that they did not really understand, and were inappropriately impatient with them to recover more quickly than was possible.

away from her. If the widow becomes dependent on the aide, it does not seem to bother either of them at this point in the encounter. This most often will take the form of frequent phone calls, or the aide will drive the widow to the social security office and the like.

The widow explores the common problems of widowhood with the aide.

One woman was worried about her child, who took out his father's picture and talked to it. And another was upset because her daughter wasn't doing well in school anymore. The aide could talk about not knowing how to help a child, could honestly normalize the behavior in the knowledge that with time the child does make an adjustment, but also recognizing the child's need to mourn which the widow doesn't always see. In the words of one widow:

"I tried not to cry in front of my children. I wanted things to be as normal as possible for them. Then my little one stopped working at school. The teacher said he was depressed. The children felt it wasn't right that things should be the same if their father was dead. They thought I didn't care about him."

As a result of talking to the aide the widow started to show the children her true feelings and her boy's studies began to improve. The aide could talk about their own children, the problems they have now as well as when their husband died and how they saw their husband's death contributing to them. They reported what worked for them and what didn't work, and were receptive of the widow's suggestions for solutions as well. They established with the widow the fact that widowhood is lonely, frustrating, that there is often a bitterness which accompanies it; that you really don't get over it, but get used to it. By so doing they seem to take the fear and

worry out of mourning and give the widow a context for her behavior which she can accept and understand. They see normal grief as extending over time, and counsel patience to the widow.

Often, the aides report that the widow tries to be strong and feels she must avoid being excessively dependent and is inadequate if she requires assistance. This feeling is fostered by people such as her doctor to whom she may complain. She is usually told she will get over it and be strong. The aide, on the other hand encourages the widow to return to get a physical check-up to verify that her symptoms are indeed just "nerves." If the doctor prescribes tranquilizers, the aide encourages the widow to use them and not to feel that she is weak and defective for needing this "crutch" in order to get through this period until she learns to find her way in her new circumstances. Over and over again the aide is told:

"You understand the void in my life."

The aide sees this as meaning that it is not always necessary to talk about it because they indeed do know.

The aide is not trying to make the widow into what she is not nor does she want her to act as she, the aide, did, but rather to accept the fact that she is going through hell to be more accepting of herself and her own needs at this time. This is something that the widow reports she does not learn from her immediate family or friends. If she does, it is because there are widows among them.

One woman was worried about her child, who took out his father's picture and talked to it. And another was upset because her daughter wasn't doing well in school anymore.

Learning To Live As a Widow

The aides talk of the needs of the widow to change from seeing herself as married to thinking of herself as widowed. This they see as the first step to recovery.

The aides identify three themes in this process. First is the need to learn to make decisions independently or unilaterally, that is, without the guidance and help of a husband: * *"The biggest decision I ever made was what loaf of bread to buy."*

The second theme is the need to learn to be alone: *"What do I do after the children are asleep? I can't stand the empty silence, and I can't watch another T.V. program."*

The third theme follows on these two in that there is a growing need to make new friends and be out with people: *"I don't get invited out by our couple friends anymore. I'm not always comfortable with them. It makes me feel even lonelier."*

As far as decision making is concerned, the aide is primarily helpful in two ways. She is not afraid to give direct advice if it is needed. She seems more willing to do this early in the contact when the widow seems confused and needs direction about for example, money, children, selling the house and so forth. In the latter phase of accommodation she is more apt to offer encouragement, ideas and support; though she is often quite pointed in telling the new widow she needs to act for herself. For a woman who has seen herself, for most of her adult life, as a partner in a marriage,

* Mrs. Ruth Abrams, research social worker in the Conjugal Bereavement Study at the LOCP has observed that in the first months after her husband's demise the new widow leans heavily on his wishes and her memories of him, and tries to do things as he would have wanted. Recovery, she observed, begins when the widow can "give up her husband's ghost", which means she is able to learn to make decisions based on her current reality.

this is not always an easy transition to make. We begin to differentiate between those widows who respond to this encouragement, get a job, learn to drive and begin to re-pattern their lives, and those widows (a small minority) who have difficulty. This latter group seems to cling to the past and to be searching for a replacement for their deceased husband who will make their decisions for them. Often they try to put the aide in this role but at this point in time she seems to instinctively repel this effort while not rejecting the widow herself. The program is too young to know how the aides can help this latter group of women pass this stumbling block.^{2, **}

To fill the loneliness of any empty evening is not easy. The aide in part helps by being available, if only on the telephone, to talk and to empathize with the problem which she, too, is experiencing. Some widows run away from this by never being home, others put all their energy into taking care of the children. The aide tries to help find a middle road. She acknowledges aloud for the widow that the consequence of running is that one day she will suddenly have no place to go and then she will be really depressed. The problem for the aide is to offer real alternatives for the widow. This brings us to the third theme which involves helping the widow expand her resources and repeople her life differently. Out of this the widow can create for herself alternatives with which to cope with her aloneness and her loneliness.

The aides have helped in two ways: They

** In a survey of psychiatric clinic records I noted that most widows who appeared for treatment, came for the first time two years after the death of their husband. These patients may come from this group, and it may be that the effort now, at the end of the first year of bereavement, may have the greatest payoff to prevent a serious emotional disturbance from developing.

have helped the widows find other groups of "single" people where they might find common interests. There are several kinds of single groups. One such group is being formed by widows who have been served by the program. They met at several large meetings arranged by the aides to discuss the problems of widowhood. Several cook-outs were also planned. These group meetings have attracted women who initially refused to see the aide or spoke to her only on the telephone. Once they came to a meeting they returned because they found:

"It helps to talk to others in the same situation. Sometimes when I get home and think about what other women have said I learn something new about myself. The only reason I came in the first place was because I was embarrassed to refuse (the aide's invitation) again. If I had realized how friendly and nice everyone is I wouldn't have been so reluctant."

Another group of women have sought out single people clubs where it is possible to meet men. These women have relied on the aide to inform them about such groups and have asked her to take them to a meeting to overcome their initial shyness.

The second way of helping has been to get these widows to reach out to other widows in their immediate neighborhood who have refused to see the aide, or who are so physically disabled that they cannot leave home. This provides the widow with an opportunity to do something for someone else as well as to make new friends. Some widows seem ready for this by the end of the first 18 months of their bereavement; and the aides are eager to share with them their role as caregiver.

As the widows move out into the role of caregiver it seems appropriate to consider ways of making them more responsible for the ultimate life of the widow to widow

program. The next phase of new activity should involve the widows served in the workings of the program. As they were helped so they can help others and thus give the program continuity and a permanent status in the community. The program is still going on.* We are only beginning to understand the unique role of the widow caregiver. At this point, however, it is possible to say the evidence seems to support our initial hypothesis that another widow is the appropriate intervener in a program of preventive intervention where the client group did not ask for the service.

Discussion

The purpose of any program in preventive intervention is to prevent emotional breakdown in a vulnerable population. While, at this point, we cannot demonstrate that we are achieving this goal in the Widow to Widow Program, it becomes clear that the aides are indeed being very helpful to the widows they reach and that in good part their ability to do so is a consequence of their being widowed themselves.

To better understand the special quality of the aides' helpfulness, two basic problems facing a new widow need examination. The first problem is that of facing the fact of widowhood; that is, accepting their changed marital status and all this involves. The second problem is to learn to manage their own lives, and to demonstrate to themselves and others that they can be and are independent.

Many women see widowhood as a social stigma. They see themselves as marked women, different from everyone else, even

* During the first year the program was supported in part by the National and New England Funeral Directors Association and in part under Grant MH-03442 NIMH. This latter support will continue for another 2 years.

carrying this so far as to see themselves as defective, that something must be wrong with them if they lost their husbands. In addition, all widows report they experience a growing social isolation as time passes after their husband's death. They no longer belong with their married friends, who they find gradually withdrawing from them. They can no longer conform to standards which society calls "normal" and they become people in a "special situation", that is, with a stigma. Goffman¹ describes this phenomenon but it is beyond the scope of this paper to explore all its ramifications for understanding the problems of widowhood. He, however, describes the function of the veteran of this role in helping the newly stigmatized person accept his lot. This is exactly the work of the widow aide. Goffman points to the need of the stigmatized individual to feel that:

"he is human and 'essentially' normal in spite of appearances and in spite of his own self-doubts. . . . The first set of sympathetic others is of course those who share his stigma. Knowing from their own experience what it is like to have this particular stigma some of them can provide the individual with instruction in the tricks of the trade and with a circle of lament to which he can withdraw for moral support and for the comfort of feeling at home, at ease, accepted as a person who really is like any other normal person.¹

Goffman further notes that the veteran serves as an example of someone who can successfully live with his stigma. In addition he functions as a bridge person to the outside world helping them to normalize and be more accepting of people in this category. First, however, they must help the new member accept his own membership in the category. The aide understands instinctively the new widow's reluctance and resistance to accepting this status. The widow is not unique in this. Goffman notes the difficulty the alcoholic, the deaf, and so

forth have in accepting their assignment to a special category. However when they do so, their hope for "normalizing" their life is increased and adjustment or recovery can be achieved. In accepting help from another member of the category they take the first step toward accepting their own membership. By the very nature of the problem then, the veteran, in this case another widow, is best equipped to help the new member. She is first a bridge to accepting the role of widow and then to helping the widow find a place for herself in the larger

What I am advocating is the development of a self help organization. It may be that this kind of organization is best suited to do the work of preventive intervention.

community. In addition, the veteran has a privileged communication with the new member which no outsider can have. The aide can say things about being a member of the category: about feelings (positive and negative), about problems it creates which if mentioned by a non-member would be considered an intrusion or an impertinence. Intervention becomes the work of the members of the category and we begin to understand the success of such self help groups as Alcoholics Anonymous and Parents Without Partners.

There is also a progression in the organization. The members move from initially being recipients of service to becoming providers of service. As a provider of service he develops a sense of independence and adequacy which brings him well on to the road of recovery, accommodation, or adjustment. This is the second need a widow has and as she in turn becomes a caregiver she develops a new sense of independence and worth. Insofar as the Widow to Widow

Program can do this, it should be able to accomplish its goal of preventing emotional breakdown in a new widow.

The self help group has several important characteristics. Primary among them are: that the caregiver has the same disability as the carereceiver; that a recipient of service can change roles to become a caregiver; and all policy and program is decided by a membership whose chief qualification is that they at one time qualified and were recipients of the services of the organization. The prototype for self help groups has been Alcoholics Anonymous, run by alcoholics for alcoholics. This program has assiduously remained independent of the formal health and welfare system, using professionals only as occasional consultants, never to make policy or direct a program.

What I am advocating is the development of a self help organization. It may be that this kind of organization is best suited to do the work of preventive intervention. What problems arise for a self help group begun in a Laboratory of a Medical School? Are these problems different for such a program started in a Community Mental Health Center or clinics.

Many mental health agencies have attempted to replicate some aspects of the success of these self help groups by employing so called "non-professional indigenous workers." Unlike A.A. these non-professionals are usually given extensive training and supervision so that they begin to adopt professional values and emulate professional techniques. If they were following the self help model, they should be making policy, developing their own techniques for helping, and the consumer of their services should be able to move into their role of caregiver. In the average agency setting this would be difficult to achieve since it would mean that the professionally trained caregiver could be displaced by his former

client. He could also potentially lose control of policy as well as of practice. This would be inappropriate and inconsistent with the mandate an agency has from the community supporting it. The goal, as I see it, should be a partnership between independent self help groups and the formal agency whose special expertise is utilized as needed.

The Laboratory of Community Psychiatry at Harvard Medical School is a research and training center and has no commitment to serve a particular population. Nor is it an agency committed to any particular technology. It does not have a staff who would be offering an additional or competing service and whose position would be threatened if clients became caregivers. It is therefore feasible for the Laboratory of Community Psychiatry to experiment in sponsoring a self help program staffed by non-professionals who meet all the requirements for being potential recipients of the service themselves. Here is a unique opportunity to learn how to stimulate the development of such organizations to do the work of prevention, to learn what form an on-going organization can take in the community, and to experiment with different forms of collaboration between the formal agency and the emerging self help group.

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Boris M. Levinson, Ph.D.

The New York City Skid Row Negro: Some Research Findings

A study of the New York City skid row Negro discloses the effects of racial, social and economic discrimination on intellectual and personality structure. Most of these men, many of whom are from the South, are either semiskilled or unskilled workers. They have a mean WAIS full scale IQ of 85, the verbal IQ being higher than the performance IQ. An analysis of data from a study of 24 matched WAIS full-scale IQs of northern and southern homeless Negro men indicated no significant differences in the factor measures for the two groups. This would seem to imply that racial, cultural and economic deprivation, whether in the North or in the South, has the same debilitating effects.

Extent of the Problem

It is estimated that there are 34,000 homeless men in New York City.¹⁵ The Bowery has a population of 7,000 homeless men.² One-third of them are Negro. In the year 1969, the Shelter Care Center for Men of the Department of Social Services of the City of New York assisted 3,885 homeless Negroes for an average of 31:0 days each (estimated by writer from 1969 Annual Report of the Shelter Care Center for Men).

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Generally speaking, the homeless man, particularly the homeless Negro, is not an isolated phenomenon. He is part and parcel of the main current of American life. Thus, the composition of the skid row population reflects the socio-economic composition of the lower strata of the city, its environs and its inner immigration. It is not the locus or the cesspool toward which all the ne'er-do-wells or mental defectives gravitate or a gathering place for "down at the heel," alcoholic businessmen, artists, poets, and college professors.

This article is adapted and updated from a paper presented at the symposium, "Negro Life in 1967", held in December 1967 at the Fall Meeting of the New Jersey Psychological Association.

Background

As is well known, the Negro people are now undergoing a revolutionary transformation in their mode of thinking, living, and working. They have changed from a predominantly agricultural people to an urban one. As a matter of fact, today the Negro is more likely to be a city-dweller than the white man.¹⁶

We thus find that thirty years ago, there were almost three million sharecroppers and tenant farmers in the 16 southern states. Today, there are fewer than 380,000, of whom 120,000 are sharecroppers. A majority of those displaced are Negroes, who are forced off the land at a rate double that of white farmers. "Many have exchanged their 'cabin in the cotton' for the broken down truck or shack of the migrant worker."¹⁷

This transformation has been accompanied by a decline in the standard of living of the majority of Negroes. While it is true that economic conditions, employment opportunities, and general living conditions have tremendously improved for the middle-class Negro, this has not benefited the lower-class Negro. Whereas in 1930 the number of unemployed Negroes was comparable with that of whites, this is no

an absolute decrease in manufacturing jobs. Thus in New York the drop was 8.27%; in Philadelphia, 3.9%; in Newark, 3.1%; and in Pittsburgh, 4.7%."¹⁴

In a sense, the skid row Negro is reenacting the history of the white immigrant of fifty years ago. With the progressive urbanization of the Negro, there has been an increase in the number of homeless Negroes on skid row.

This can be highlighted by the following: During the depression (1935), only seven to twelve percent of the unattached transients were Negro.⁶ In Chicago in 1934, 15 percent of the unattached persons applying for relief were Negroes. It is to be noted that these men were not considered homeless, but only unemployed. Of course, a small number of them were also homeless. However, the estimated number of Negroes on skid row in Chicago in 1957-58 was already 9.2 percent. Correspondingly, during the same period the estimated number of Negroes on Philadelphia's skid row was 14.7 percent; and in Minneapolis, it was 4.5 percent. The numbers have since risen appreciably.

To illustrate, in a study conducted in 1945, the percentage of Negroes among homeless men was eight.⁹ This increased

Unlike the migrant worker, the homeless Negro rarely has a nostalgic yearning for the past . . .

longer true; and, as is well known, the rate of unemployment among non-whites is now twice that among whites.¹⁴ There has been a decrease in the need for unskilled labor in both the South and the North. Over one-third of the nation's Negroes were in agriculture in 1930; less than a tenth were in agriculture in 1960. "However, the Negroes coming to the city coincided with

to 22 percent in 1955,¹¹ and, in 1965-66, over one-third of the homeless population was Negro.¹³ These studies have revealed that over two-thirds of the New York skid row Negroes are from the South.¹³ This finding has been corroborated for New York City⁸ and for Chicago.¹

When unattached Negro men arrive in New York City, have no family or friends

to assist them, and are unable to find immediate employment, they tend to drift to the Bowery. Here is the area of the City with the lowest cost of living. It has labor markets for unskilled workers and private and public welfare resources that care for people on a minimal basis with a minimum of red tape.

Most of these men are either semiskilled or unskilled workers who never married or who are separated, divorced, or widowed.

In a sense, the skid row Negro is reenacting the history of the white immigrant of fifty years ago.

Their mean age is about 37, and they left school in the ninth grade. The vast majority of these men are not alcoholic. They are younger, in better physical health, and of somewhat inferior socioeconomic background and education, compared with their white compeers.¹¹ These men have a mean WAIS full scale I.Q. of 85, with the verbal I.Q. higher than the performance I.Q.

D. J. Bogue has similarly found that in Chicago "in comparison with the general skid row population there are very few alcoholic derelicts and heavy drinkers among the Negro men. Many of them are merely workingmen searching for work who live there because the price of other housing is beyond their means."¹

The Negro in New York City's skid row is as restricted by his color and subjected to as much discrimination as in society at large. It is not surprising, therefore, to find that the skid row Negro prefers to live in different Bowery hotels from the white man, and has a greater tendency to stay in his own group, to frequent Bowery bars that cater mostly to the Negro denizen of

skid row, and to "shape up" for available casual employment at a different location from the homeless white man.¹⁵

Another significant factor that brings these men to the Bowery is alienation. Generally speaking, "the homeless person is an alienated personality, and modern life tends to increase man's alienation from himself, the product of his labor, his family, society, and nature itself. . . . Alienation, although it leads toward the development of homeless personalities, does not necessarily lead to the Skid Row."¹³ The white homeless man has given up his commitment to the values of our society; the Negro homeless man was never committed to these values.

Most homeless men have had a rather stormy childhood. As infants, most of these men were exposed to inadequate, casual relationships with their mother or mother substitutes, who in most cases did not give them adequate or consistent care. They were forced to take care of themselves at a very early age. From an impoverished childhood, they were thrust into adulthood without having been given a chance to acquire social skills during adolescence.

Their ego and superego formations have been consolidated on the basis of unsatisfying and occasionally degrading and brutal socialization experiences.⁸ They have had too many inadequate models (fathers) to identify with. Their self-concepts are fragile. The homeless Negroes, in most cases, have no intimate friends with whom they can share their experiences and thus secure some catharsis. These men are very seldom motivated by approval or disapproval and have little impetus to change. They feel worthless and rejected and do not care for either themselves or others. They are passive and apathetic, and have a low frustration tolerance and little faith in themselves or

in their ability to change their status. They look to outside authorities such as the social worker, the policeman, or the bartender for leadership and a resolution of their problems. Although they are unhappy about their lot, they do not raise any fundamental questions about how they got to skid row and where this will lead them.

Unlike the migrant worker, the homeless Negro rarely has a nostalgic yearning for the past; he seldom looks back to a childhood paradise that never existed. He is concerned with the present and pays little heed to the future.

We have found that, generally speaking, the dynamics of a family in which there is an inadequate male identification figure may contribute to the development of the homeless personality.¹² Since intelligence is a facet of personality, this would indicate a somewhat different pattern of abilities on skid row or, to use another term, a different "structure of intellect". We did find a somewhat similar psychometric pattern in all skid row populations that we studied.¹⁰

Tellegen and Briggs¹⁰ have shown how the factorial structure of the WAIS³ may be adapted in the analysis of WAIS patterns. WAIS data are analyzed in terms of the following factor measures: Verbal Comprehension (subtests: Information, Comprehension, Similarities and Vocabulary), Freedom from Distractibility (subtests: Arithmetic and Digit Span), Perceptual Organization (subtests: Block Design and Object Assembly). However, in Tellegen and Briggs' analysis, Picture Completion, Picture Arrangement, and Digit Symbol were not included. Cohen³ found that Picture Completion had a factor D that was "a quasi-specific which is not interpreted other than by calling it a Picture Completion factor." Picture Arrangement, on the other hand, loads significantly in the

perceptual organization factor at ages 25-34 and negatively for ages 45-54, whereas factor E is also a "quasi-specific" and can be identified as a Digit Symbol factor.

Following the paradigm set by Tellegen and Briggs we reanalyzed the data of a study¹² in which we matched the full-scale WAIS I.Q.s of 24 pairs of northern and southern Negro homeless men in terms of the following factor measures: Verbal Comprehension, Freedom from Distractibility, Perceptual Organization, Picture Completion, and Digit Symbol. We omitted Picture Arrangement since some of our subjects were within the age range of 45-54.

There were no significant differences in the factor measures of the two groups. This indicates that the men have inferior visual and perceptual abilities. Apparently these men did not have an adequate exposure to early perceptual learning experiences. Therefore, according to Hebb's thesis,⁷ they developed a perceptual deficit. These men also had poor rote memory and difficulty in abstract concept formation, which may indicate that they had not yet progressed from operations with objects to operations with symbols that represent objects.¹⁸ These findings are in agreement with those of other studies of children from culturally and socially disadvantaged groups of our population.⁴

Discussion

We must consider the social context in which these tests were run and their meaningfulness to the subjects. The homeless Negroes had come from small family circles and very limited groups of associates. There was very little need of speech, as there was an almost instantaneous understanding of each other's needs. Of necessity, the developed speech systems, based

on segmented and narrow life experiences, could not fail but be reflected in the WAIS scores. Furthermore, we know that these men possess certain survival skills, developed as a result of their aversive life experiences, that are not measured by the WAIS.

It is instructive to observe that social and economic deprivation, no matter in what context it occurs, has a similar effect on cognitive abilities.

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The Role of the Psychiatric Consultant in the State Rehabilitation Agency

A study of the use of psychiatric consultants showed that counselors in a state rehabilitation agency used them to evaluate clients' eligibility for services. Once the case was accepted, the counselor rarely turned to the consultant for services. The authors believe that this infrequent use may be a result of role conflicts and suggest that roles be redefined to make the consultant more of a tutor than arbiter of case determination.

The extension of psychiatric consultation to community agencies and large organizations has been a subject of considerable discussion. Some have felt that the traditional image of the doctor as healer of patients may be seriously distorted and impaired by the assumption of consultative roles unrelated to patient care. This problem becomes particularly acute when the psychiatrist is requested to function as an evaluator, as consultant to the courts, or as member of an admissions committee.² In these roles, he is clearly functioning as administrator, not healer. A less clear situation is presented by the psychiatrist func-

tioning in a college clinic servicing the needs of students with maladaptive behavior. The college psychiatrist is faced with the dilemma of treating the student for clinical reasons or of intervening in behalf of the student to circumvent the rules of the bureaucracy in alleviating the student's stress.³ A third situation is one in which the psychiatrist functions as both evaluator and healer for large organizations such as corporations, government, and social welfare agencies which refer an employee or potential recipient of services for an evaluation to assess emotional strengths and weaknesses. As a result of the psychiatric report, the person undergoing evaluation may qualify or be rejected for services, may be retained or fired, or may be placed in a quasi-therapeutic regimen in

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which his eligibility for continued services or continued employment is made dependent upon obtaining psychotherapy.

The role of the psychiatric consultant in the state rehabilitation agency is crucial in the selection and acceptance of referrals of persons with diagnosis of mental disability. The formal role of the psychiatric consultant requires him to review and evaluate

Some counselors feel that the psychiatrist has the final word on acceptance of a psychiatric client for service, despite the fact that the determination of eligibility is clearly outlined in the counselor's duties.

the history of persons with mental disability by means of medical records, to complete the medical consultant's appraisal form, to assist in determining the limitations of the client for work and to give recommendations on which clinics, hospitals, and psychiatric specialists can provide further diagnosis and/or treatment when needed. Upon request, the consultant also reviews the history of persons with secondary psychiatric involvement. Since the records of every person with mental disability must be reviewed prior to acceptance of the person for rehabilitation services, the psychiatric consultant wields considerable power in the administrative procedures of the state rehabilitation agency.

Methods and Subjects

In order to analyze the role of the psychiatric consultant and to determine the extent to which it is fulfilled, an operational research study was conducted in a large, urban office of a state rehabilitation agency. This office housed a group of 14

rehabilitation counselors with varied educational and work experiences. A majority had master's degrees, and seven of the 14 had some specialized training in vocational rehabilitation. With the exception of three persons, their work experiences in vocational rehabilitation ranged from one to seven years, with a mean of three and a half years. Their experience as counselors in the state agency ranged from one to seven years. Twelve counselors were carrying general caseloads and two were carrying predominantly mental disability caseloads. In educational and work background, they were similar to other counselors employed by the agency. The setting was representative of a public agency located in a crowded, urban area. The staff was overburdened by demands for increasing services from a large caseload. Staff was constantly struggling to keep up with the demands, and one line supervisor was expected to handle 14 counselors.

During a six-month interval, 191 persons with mental disability were referred for determination of eligibility for vocational rehabilitation services. Of the 191, 161 had a diagnosis of primary mental disability, including psychosis, psychoneurosis, alcoholism, drug addiction, and personality and character disorder. An additional 30 clients were referred with secondary psychiatric disorders. Whereas psychosis accounted for 46 percent of primary mental disability referrals, it accounted for only seven percent of secondary psychiatric referrals. This situation was reversed for personality and character disorders: they constituted 50 percent of secondary referrals and only 17 percent of primary referrals. Psychoneurotics constituted approximately two fifths of both groups. Although no explanation of this variation in diagnosis can be given with certainty, it can be inferred from the pat-

tern of referral sources that primary disability referrals generally came from the state mental hospitals, where the diagnosis of psychosis was most frequently given, and secondary referrals came more frequently from the community, or from hospitals other than mental hospitals. Ten clients with secondary psychiatric disability had a primary diagnosis of mental retardation, and eight had a diagnosis of epilepsy.

Each client of the agency was followed for a minimum of six months and a maximum of one year from the date of referral. An investigation of individual case records was the primary source of data for the analysis of the use of the psychiatric consultant in evaluation of individual cases. The notes of the mental health supervisor who had presented cases to the psychiatric consultant during the study period were made available. In addition, the investigators were permitted to sit as observers of the sessions with the psychiatric consultant in which individual counselors presented cases for review.

A questionnaire was constructed and given to the counselors to determine their perceptions of the role of the psychiatric consultant. The questionnaire was broken into two parts: the first part consisted of generalized statements about the consultant and elicited overall global attitudes; the second part consisted of defining the consultant's role in a number of specific areas and determining the extent to which the counselor perceived the consultant as helpful in fulfilling his role.

Findings

Sixty-one percent of the sample were presented to the psychiatric consultant for evaluation and review. Fifty-four percent of persons with diagnosis of primary mental disability were reviewed whereas all with

secondary mental disability were seen. With one exception, all active cases (both open and closed) were reviewed, whereas only 26 percent of those cases still in referral at time of study or closed in referral were seen.

Persons with mental disability who are accepted for rehabilitation services (active status) must be evaluated by the psychiatric consultant. Other persons may be closed from referral without the benefit of the consultant's advice. That all clients with secondary disability were reviewed is an artifact of the study, since secondary psychiatric disabilities were identified by means of the consultant's list of clients evaluated.

In order to determine the extent to which the psychiatric consultant is used, the number of times and stages when cases were presented for review were measured. Sixteen percent of the 117 persons presented for psychiatric appraisal were seen for additional consultation more than once. Ninety-three percent of the cases presented for appraisal were reviewed once before acceptance. Of the 11 cases seen after acceptance, six were persons with primary physical disability in whom psychiatric symptoms became manifest after acceptance for rehabilitation services. Except for five persons, all with diagnosis of primary mental disability were seen before acceptance for services. Counselors did not obtain psychiatric consultation while clients were receiving rehabilitation services.

In analyzing counselors' attitudes toward the psychiatric consultant, two indicators of attitude were taken. First, generalized statements about the role of the consultant were presented for approval or disapproval on a five point scale. Second, counselors were asked to rate the helpfulness of the consultant in a number of key areas and to determine whether these areas legiti-

mately fall within the consultant's role. These areas included: evaluation of the client; determination of eligibility; determination of existence of disability; determination of work potential; determination of need for therapy; how to most effectively deal with the client; clarification of vocational goals; gaining realistic expectations for the client; formulation of an occupational plan; and determination of readiness for training.

On the whole, counselors held favorable attitudes toward the consultant in their responses to the generalized statements. Two counselors held negative attitudes toward the consultant, four held strongly positive attitudes, and the remaining were positive. Counselors generally were in agreement on the following items: the consultant's effective use of his time; the signing of necessary forms; respecting the role of the counselor; helping the counselor to understand better his client. Less agreement was obtained on items concerning the counselor's attitude toward the consultant's recommendations. Counselors were divided on whether to follow or to resist the recommendations. There was also disagreement on whether the consultant is guided by the counselor's understanding of the case.

The second indicator of attitude toward the consultant was obtained by taking discrepancy scores between how helpful the consultant was perceived to be in certain areas and how important the consultant's role should be in similar areas. On the whole, there was minimal discrepancy between what the counselor perceived that the role of the consultant should be and how helpful the counselor found the consultant in carrying out his role. Counselors felt the consultant should hold a strong role in total evaluation of the client, determination of existence of disability, de-

termination of need for therapy, how to deal effectively with the client, and giving realistic expectations for the client. It was felt that the consultant had a moderate role in the determination of work potential, the clarification of vocational goals, and the determination of readiness for training. Counselors felt that the consultant's role in the formulation of the occupational plan should be either minimal or nonexistent. The item on determination of eligibility produced an equivalent response among counselors; half of them thought it definitely fell within the consultant's role and half thought it was not his role. In addition, it was thought that counselors who held a more favorable attitude toward the consultant would be less discrepant in their perceptions of what the consultant's role should be and how helpful the consultant was in carrying out his role. This hypothesis was rejected, although a strong relationship was found between favorable attitudes and less discrepancy.

Discussion

The role of the psychiatric consultant in the state rehabilitation agency needs to be clarified. Although the consultant's role and duties have been formally outlined in the state manual of operations, his informal role may be quite different. A distinction needs to be drawn between the consultant's formal role in reviewing and evaluating client records and his informal role in providing guidance in the counseling of a psychiatric client during the rehabilitation process. This study indicated that counselors tended to use the consultant as an evaluator or approval agent for clients which the counselor wanted to accept or reject for services. After the case was accepted, counselors infrequently returned to the psychiatrist for help in case services.

One explanation for minimal contact between counselor and psychiatrist during the rehabilitation process may be role conflict between the two professions. Counselors feel that they are trained and qualified to manage the vocational problems of their clients. Moreover, some counselors with client-centered orientation might feel that counseling and therapy are synonymous. From this vantage point, they are performing a therapeutic function comparable to that of the psychiatrist. In bringing their cases for review to the psychiatrist, a person who holds greater prestige value in the professional community, counselors may feel they are jeopardizing their own professional role and function. Counselors might be fearful of being judged on their professional treatment of the case, or of being analyzed by the psychiatrist. Therefore, they tend to bring the case for appraisal, but are reluctant to return to the psychiatrist for advice and guidance.

Another explanation might be that the counselor feels threatened by emotional problems. They might be unwilling to spend a long period in reevaluation of clients with baffling emotional problems requiring complex treatment and resources and with uncertain vocational outcome. These clients differ from the physical restoration case requiring diagnosis and hospitalization, or from the school case requiring further vocational training. If vocational problems were the only consideration, then the counselor of the emotionally disturbed would be more secure in his role as vocational expert.

Counselors' perceptions of the role of the psychiatrist vary greatly. They are divided on the question of whether the consultant or counselor determines eligibility. Some counselors feel that the psychiatrist has the final word on acceptance

of a psychiatric client for service, despite the fact that the determination of eligibility is clearly outlined in the counselor's duties. Counselors are doubtful of their own responsibility to establish eligibility and to come to some decision on acceptance or rejection of their clients. By reliance upon the psychiatrist the counselor is able to postpone making a decision until the psychiatrist has appraised the case.

The psychiatric consultant, when functioning in the role of administrator, poses a threat to overburdened, underpaid mental health counselors and case workers.

Attitudes toward the use of the psychiatric consultant vary greatly among individual counselors. Counselors might be quite willing to accept the psychiatrist's appraisal of the case, but unwilling to follow his recommendations for further diagnosis and therapy. When the psychiatrist impinges upon the counselor's role as coordinator of case services, the psychiatrist holds less power in the rehabilitation process than when he acts as an evaluative agent.

Recommendations for further clarification of the psychiatric consultant's role might include differentiation from that of the medical consultant, who appraises the functional capacities of the disabled person, determines the limitations existing in regard to disability, discusses the extent of disability, and evaluates the medical prognosis.⁴ After this has been determined, the medical consultant's role is minimal with the exception of cases where recommendations for surgery and hospitalization are required. Although the psychiatric consultant follows the procedural format of

the medical consultant, he may function in a broader way. He may be used more extensively as teacher and advisor in establishing a therapeutic relationship with emotionally disturbed clients. With few professionals available for counseling and treating the emotionally disturbed, the psychiatric consultant might be used effectively in his tutorial role without seriously impinging upon the counselor's role as vocational expert or counselor-therapist.

The implications for psychiatric consultation in community agencies are many. The psychiatric consultant, when functioning in the role of administrator, poses a threat to overburdened, underpaid mental health counselors and case workers. These professionals may see the psychiatrist not as a supportive arm in the provision of mental health services, but as a judge of their capabilities in counseling the emotionally disturbed. This perception of the psychiatrist's role is strengthened when the administrative and legal procedure such as in the state rehabilitation agency requires a positive appraisal before services may be rendered. It is contended that the psychiatric consultant has another role: tutor and advisor. This role can be enlarged when he is perceived in a coordinate position in relation to the counselor. The administration and coordination of case services, including eligibility determination, rests solely with the counselor. When counselors are secure in their own roles, the use of the psychiatric consultant at any point along the rehabilitation continuum from referral to job placement will be increased, broadened, and intensified.

The findings in this study raise the question whether the psychiatric consultant can function optimally as tutor in a context where the counselor brings his cases routinely and perhaps involuntarily to the psychiatrist for appraisal. The tutorial

type of consultation requires free interchange between consultant and consultee in which a relationship of trust is built between the two active participants. The consultee must feel free to bring his problems without suffering a sense of guilt due to personal inadequacy or mismanagement of clients.¹ A relationship of trust can be developed where the psychiatrist functions in a non-administrative role in relation to the counselor.

Perhaps the role of the psychiatric consultant in the state rehabilitation agency should be divided between two persons functioning differently: a psychiatric consultant in the administration of the mental health program; and a psychiatric consultant with the counseling relationship between counselors and clients. The first person would act primarily as an administrative consultant to the mental health and district supervisors. He might also encourage group discussions for counselors and district supervisors as joint participants to increase group cohesiveness and stimulate a feeling of participation in administrative policy. The second person would act primarily as tutor to counselors, including in his functions education, explanation, interpretation, and guidance with individual problems.

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Catholic Seminarians in a Secular Institution

Thirteen Maryknoll Seminarians joined the Case Aide Program at Boston State Hospital. They worked with four women and nine men, typical of patients found in the back wards of state hospitals. As a result of the seminarians' intervention, most of the patients were able to develop a warm trusting relationship, and to take on greater responsibilities both in and outside the hospital. Research concluded that the seminarians' preoccupation with self-knowledge was considerably greater than that of Harvard Student groups previously tested, and was in keeping with the purpose of the novice year: to decide upon the priesthood as a career. The overall assessment score of the effectiveness of the volunteer as a therapeutic trainee was considerably higher for the seminarian group than for the Harvard Student group.*

The Case Aide Program

The Case Aide Volunteer training and demonstration model at the Boston State Hospital had as its purpose to: (1) Provide patients and volunteers with a meaningful one-to-one relationship under skilled super-

vision; and (2) To train and further educate the volunteer in meeting urgent manpower shortages in the State Hospital.

The program, the first and prototype for all state hospital non-student volunteer case aide programs in Massachusetts, first came into being in September 1963 when a small grant from the Permanent Charities Foundation of Boston was made available to demonstrate the theory that intelligent and highly motivated community volun-

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teers, under the supervision of the trained psychiatric social worker, could help chronically ill patients. A result of our initial demonstration showed that the very special way the volunteer intervened with mentally ill patients, a way which could be described therapeutic, partly educational and partly supportive, made possible a surprisingly high degree of patient improvement. This result was identical with that of a project done in the early 1960's with Harvard and Radcliffe volunteers.^{4,4} This student volunteer program was the model for the original volunteer demonstration grant at the hospital.

The Volunteers: The group of 13 Maryknoll Fathers Seminary volunteers unlike other case aide volunteer groups, was the first religiously affiliated group to join the program. These men, between the ages of 21 and 27, were all white and came from devout homes of varying socio-economic backgrounds.

Collectively, for their ages, the life experience of these particular seminarians was far more limited and restricted than for other non-religious student volunteers who have also been members of the Case Aide Program. Every seminarian had graduated from a Catholic supported college, and most of the students had attended a private Catholic supported high school; two attending the seminary for their total secondary school experience. Only one of the group had been in the armed forces prior to his membership in the seminary.

Patient Selection: The patients selected by the supervisors for the seminarians to work with were typical of the long time hospitalized, chronic population, at the Boston State Hospital. They included four women and nine men between the ages of twenty-eight to fifty-six.

Their diagnoses were characteristic of

those found in the back wards of state hospitals. Nine were diagnosed as chronic schizophrenics; of these five were considered to be paranoid, two were catatonic, and two simple type. Two were diagnosed as depressed, and two were diagnosed as having chronic brain syndrome due to alcoholism. Of the thirteen patients chosen, two were Protestant, six Catholic and four Jewish. One was a Chinese born Buddhist.

Supervision: The supervision of the seminarians at the Boston State Hospital was undertaken by two members of the Psychiatric Social Work Staff of the Case Aide Program.

The objectives of supervision were to "tune in" to the individual student in terms of: (1) his ability to establish a rapport with his patient; (2) the goals which might be realistically reached for the patient, as well as; (3) his own needs and capabilities for self-awareness, growth and maturity.

It is the aim of the program that while engaging in "friendship therapy", the volunteer must view himself as a person who has both an interest in, as well as an awareness of, the patient's capacities and limitations. Each seminarian was helped to develop his own particular style with his patient, based upon the recognition of his increasing ease and comfort in dealing with a mentally ill member of society in a chronic ward setting; his own ability to sharpen his skills in assessing the needs, strengths, and liabilities of the patient; and to define, and help work out appropriate goals for the patient. At first this seemed to be an enormous task for the seminarian as he, unlike other college students, or more mature volunteers, had no role model to which he could adapt. His previous experience with people was mainly involved with family or friends and his ex-

It appeared initially that these young men expected to give to their patients, using the role model of a priest "giving" of himself to his parishioners, but not to be the recipient of friendship from his patient.

posure to the community had primarily been in connection with the religious. He had learned that peoples' expectations of him were in terms of the expectations made of a priest, i.e., his ability to eventually offer the sacraments of the church; his future theological expertise; his influence in the missions as a religious pragmatist.

Once the student became comfortable in his relationship with the patient and formed his own impression of the patient's capabilities and limitations, the supervisors then suggested that they look at the hospital records to get further insight and/or a different point of view about the patient, in terms of a clinical diagnosis, prognosis etc. Records were therefore read some three to four months after students had engaged the patient in a relationship.

When situations relating to patients' jobs, home placement, vocational testing, and the like, were deemed appropriate by the students and supervisors, the volunteer was then expected to be the pivotal person to relate to the ward or rehabilitation staff for advice and help in planning. It was with the volunteer's help that specific plans were worked through for the patient.

As a result of the group and individual supervisory sessions, the student became comfortable in his role with the patient, his ability to work independently, develop skills, determine problems and define goals.

The student's rapport with his patient was in most instances both mutually profitable and beneficial. The seminarians learned how to enter into a give-and-take

relationship. It appeared initially that these young men expected to give to their patients, using the role model of a priest "giving" of himself to his parishioners, but not to be the recipient of friendship from his patient.

As the seminarians became more committed to their patients, so too did they become more relaxed and comfortable in the group and individual supervisory setting. For many, this was the first time that they were supervised by a woman, and their first exposure to women whose backgrounds and philosophy was considerably different from their own. The students were young, idealistic, religiously oriented and socially naïve. The supervisors represented the middle-class married mother, part-time professional psychiatric social worker, psycho-dynamically oriented woman, without close religious ties.

The supervisors had much to learn in their understanding of seminary students, primarily, the philosophy of dedicated commitment to the Church and its implications for the individual considering such a vocation. The students were able, as the year went on, to communicate verbally and attitudinally, not only what they individually would be giving up for their belief, but far more importantly; what they felt they could give as professionals in the Church. They viewed the concept of giving as an end unto itself and felt that ideally they would be fulfilled as a result of their involvement as missionaries.

As was expected at the Seminary, several students decided to change their careers during this novice year. Five students chose to leave the Seminary. In every instance, there was discussion with the supervisors regarding their feelings of leaving the seminary, and the system in which they had been nurtured. Advice was sought regarding their future plans. While these

five felt they could no longer remain in the seminary, for various personal reasons, they have all indicated a strong desire to continue to be of help to others. Two subsequently joined the Peace Corps; two are planning careers in psychiatric social work and one is contemplating a vocation in personnel counseling.

According to Father Diffley, a faculty member at the Seminary, the Case Aide Program crystallized the need for a more highly specialized clinical pastoral chaplaincy program. Subsequently, Maryknoll made arrangements for forty-five of their students to work in the Clinical Pastoral Training Program on a two day a week basis with intensive group and individual supervision being offered by pastoral counselors. This program, which was started in October 1968 through the present time, in connection with the Andover Newton Theological Seminary, offers the student a still more intensive educational experience utilizing the novice as a chaplain, a method which in turn clarifies his potential vocational role.

Research Findings

As a part of the Case Aide Program's research, a questionnaire and two scales³ were administered for use by the students and their supervisors. One scale was designed to determine the motivation of volunteers coming into, and becoming members of, the Case Aide Program. A second scale, "The Assessment of Therapeutic Trainees", was designed for use by the supervisors in assessing the effectiveness of a volunteer as a therapeutic agent with a mentally ill patient.

Upon coming into the program, the seminarians were required to complete a volunteer questionnaire designed to ascertain descriptive face sheet data, as well as

information regarding motivation for joining the program. The results of this questionnaire strongly indicated that all of the students wanted to be of service to the patient, i.e., to help the mentally ill.

Within a few weeks after the students had been assigned their patient, they were then asked to complete the motivation questionnaire of 56 separate items. The M.Q., as it is called, is composed of seven sub-scales; each relevant to a specific area of motivation for volunteering. The areas are; social, career, escape (from one's environment), mental health knowledge, challenge, self-knowledge and service. The sub-scales of the Maryknoll Seminarians were compared with a group of former Harvard Students previously tested.

Interestingly enough, despite the fact that the students originally answered the initial questionnaire regarding motivation in terms of service to patients, the overwhelming majority (12 of 13) ranked extremely high in the sub-score of **self-knowledge**. While no test for statistical significance was made, the self-knowledge score was found to be considerably higher for the Maryknoll Seminarian Group (.78) than for a group of Harvard Students (.59).

We wondered why the seminarian was so pre-occupied with self-knowledge and thought about his case aide experience in relation to his activities outside the hospital. As the purpose of the novice year in the Maryknoll Society was to determine whether or not the seminarian was truly serious about his intentions regarding his commitment to the priesthood, it was reasoned that the more self-awareness, insight, or self-knowledge the seminarian had at his command, the clearer and firmer a resolution of his commitment would be to the Church.

As a group, the seminarians' **mental health knowledge, escape and career moti-**

vation sub-scales were quite low. Thus, this group did not come into the program to learn about mental health, to escape from their environment, or to utilize the case aide experience as a potential career testing ground. The Harvard Students

some five to six months after the group entered the program.

The total mean score for thirteen seminarians was 23.4. Their score was considerably higher than for thirty-one Harvard Students previously tested, the latter's

The seminarians' prime underlying motivation was decidedly one which involved a deepening and broadening of self-awareness.

tested showed approximately twice as high ratings in these three sub-scales. In terms of the remaining three sub-scales; social, challenge, and service, there is little difference percentage-wise between the rating for the Maryknoll Group and the Harvard Group.

Generally then, it can be stated that other students we had occasion to supervise, as well as those Harvard Students previously tested, came into the program with very different underlying motivations from those of the seminarians. Often the former were very sophisticated, extremely intelligent, and perceptive and wished to make use of the field work experience at the hospital either to enhance their own theoretical knowledge; to test the possibility of a mental health career or to escape from the college classroom environment. The seminarians' prime underlying motivation was decidedly one which involved a deepening and broadening of self-awareness.

A second scale, *Assessment of Therapeutic Trainees* was designed for use by psychiatric social work supervisors in evaluating characteristics associated with therapeutic competence.¹ Each supervisor in the Case Aide Program was asked to assess every volunteer in his group on the 27 items included in the scale. The scales were to be completed after the supervisor felt he knew the volunteers well enough to make such an assessment. For the group of seminarians, the scales were completed

total mean score being 17.3. Sub-score comparisons between the Seminarian Group and the Harvard Group could not be made as the latter sub-scores were not available at the time of this writing.

In attempting to understand and name the qualities of the effective volunteer (a high assessment score) it is useful to look at the items themselves. The first sub-score describes a person who is *tolerant, empathic, and compassionate*. As expected, the seminarians scored extremely high in this sub-score. Out of nine items in the sub-score, ten students totaled either eight or nine. One would surmise that tolerance, empathy and compassion for one's fellow man are traits as important to the successful priest as to the successful mental health case aide volunteer.

In respect to the second sub-score; that of describing the person who *respects the dignity of the patient* as an individual, and does not need to emphasize *status differences*, once again, the seminarians scored extremely high.

The third sub-score concerned itself with the volunteer's *involvement in the therapeutic process* such as being flexible and capable of *imagination and spontaneity* in trying out *new approaches* for solving the patient's problems. Ten students, of the thirteen, received a "perfect score" in this area. Contrary to the supervisors' early expectations in comparing their own experience with other student and non-stu-

dent groups in the program, the authors believed that the Seminary Group's curiosity and initiative were somewhat lacking. Their creativity and imagination seemed more repressed when they first came into the program than other groups.

The items in the fourth sub-scale depicted an **objective** and emotionally controlled person who had **self-insight** and was not hampered by outstanding personality limitations which disrupted his work with patients. The Seminary Group, as a whole, scored lower on this item (six received perfect scores) than on the previous sub-scores. The Supervisors' rating of the groups' need to gain self-insight, as seen in this sub-score, was most certainly in accord with the high "self-knowledge" sub-score in the motivation questionnaire previously described.

The fifth and sixth sub-scales were involved with **good relationships with patients and good relations with supervisors**. In both these areas the students scored very well. The research documents much of the material already discussed.

The seventh sub-scale concerned itself with the volunteers' **capacity to learn and grow**. Over half (7) of the group received a perfect score of seven, while four more scored six points. One might assume that students would score well in this area, otherwise, they probably would be wasting their time in an academic environment.

The eighth sub-score described the volunteer as **psychologically sensitive** and trying

to understand his patient as a complex human being. The result of this sub-scale (10 received perfect scores) was not perplexing as one, once again, must assume that sensitivity to people is a personality prerequisite for the priesthood.

Finally, the effective volunteer was generally **optimistic** about **therapeutic outcome**. He showed the ability to **sustain high interest and involvement** and backed up his faith in the patient and his commitment to the patient's progress with **energy, initiative, and action**. The high score that the seminarians received in this sub-score reflect his overall faith and lifetime commitment to God and man.

It was felt that utilizing seminary students in the Case Aide Program at the Boston State Hospital has been a most rewarding experience for the patients, the students and their supervisors.

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Walter Tietz, M.D.

School Phobia and the Fear of Death

It has been known for some time that the psychodynamics in school phobia could be best understood as a variant of separation anxiety.⁹ Furthermore, it has also been observed that school phobia is part of a natural history of depressive disorder and that there seems to be a depressive family constellation in the school phobic, occurring in successive generations.¹ The prognosis in school phobia seems somewhat dependent on age. It is relatively good in children prior to adolescence and relatively poor in older children.⁷ In younger children the dynamics of separation anxiety are prominent: whereas in older children there is more widespread insidious characteriologic family disorder where a depressive family constellation dominates. It is the purpose of this paper to present a series of cases of school phobia occurring in adolescents from 11-15 years old, all associated with death in the family, where the school phobia served as a façade for the real fear which was fear of death. An attempt will be made to understand this in the theoretical framework provided by Bowlby.

Case Histories

Case 1

Patient is a 14-year old white female, who developed psychosomatic complaints and school

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phobia shortly after her maternal grandmother's death, which was coincidentally followed by a move of the family to a new section of the country where there was no extended family. The mother was an intensely phobic woman always fearing the death of her own mother and was extremely overprotective to her children because she had always feared some harm might come to them. The patient became obsessed with fear of her own mother's demise and became afraid she too would die.

Case 2

Patient is a 15-year old white male, who became acutely disturbed about two months after a serious accident where he was severely crushed, incurring a fracture of the arm. He began to feel weak, helpless, and felt he could not exist without his mother being constantly with him, resulting in his failure to go to school. The patient literally felt he would die if he were not with his parents. Furthermore, the father also was obsessed with the fear of death.

Case 3

Patient is a 14-year old white female, who developed psychosomatic complaints and intense school phobia when, one and a half years after her grandfather died, her maternal grandmother who was dying of cancer moved into her home. She was afraid that her mother might also die, leaving her alone, susceptible to death. As a result, she was afraid to go to sleep, equating sleep with death, and afraid to go to school because then her mother might die.

Case 4

Patient is a 12-year old white female, who became acutely upset when her mother had to leave for the East to attend the funeral of the maternal grandmother. She began to develop

various psychosomatic complaints, and finally would not go to school at all.

Case 5

Patient is a 12-year old white male, who had been extremely anxious for the past four months, since his paternal grandfather died in Israel. The father had gone to Israel and stayed there for a month. Upon his return, the father became irritable, anxious and depressed. About two weeks after the father's return, the boy became frightened, had various psychosomatic complaints, and refused to be left alone. He always wanted one of his parents to be at home with him, and he refused to go to school. He verbalized the fact that he was afraid something might happen to them, especially his father. When the parents would leave him, he would go into the room with his sister in order not to be alone.

Case 6

Patient is an 11-year old white male, who had had a school phobia ever since he started school. When he started school at age six, his father had been dead for one year, following a bleeding duodenal ulcer. His mother and paternal grandmother, who moved in with them, constantly reminded him of his father's death. The death of the remaining two brothers of his father over the ensuing years only intensified the feelings of loss of his father. Furthermore, the family belonged to a religious sect which predicted the death and destruction of mankind in the next few years. The boy was constantly afraid his mother might die and that this would leave him helpless and weak. He became depressed and developed suicidal ideation, while at the same time he was afraid of his own death and destruction.

Discussion

Thus, it can be seen that death, or fear of death can be a precipitating event in the genesis of a school phobia. In all the cases presented here, there was not only a school phobia, an active death or fear of death of the parent, but it was also always associated with a fear of the child's own death.

How can this best be understood? John-

son⁹ and her co-workers have suggested that the syndrome of school phobia be redefined in terms of an etiologic diagnosis, namely, separation anxiety. Johnson has defined separation anxiety⁹ "As a pathological emotional state in which child and parent are involved in a relationship characterized by an intense need on the part of both to be in close physical proximity." Sperling¹⁰ sees school phobia as a neurosis characterized by fixation at the anal-sadistic level, the time where individuation and separation should occur. It thus represents a failure to resolve the normal infantile symbiotic relationship the mother has with the child, and is interpreted as an acute separation threat which has the implied meaning of impending death.

The problem of separation anxiety and its relationship to grief and mourning has been studied intensively by Bowlby. According to Bowlby,² the child develops a tie to the mother as a direct outcome of the activation of a number of instinctual response systems among which are crying, smiling, sucking, clinging and following. When these instinctual response systems are activated and the mother figure is temporarily not available, the response is one of separation anxiety.³ When the mother figure appears to be permanently absent, the response is one of grief and mourning.⁴

Thus, the relationship of separation anxiety and mourning is determined by the temporary or permanent absence of the mother figure. Viewed in this light the clinical observance of the association of school phobia in the child and depression and depressive constellation in the family, can be readily understood.

Furthermore, if one feels that the attachment behavior to the mother is basically instinctual and has survival value, failure to resolve this attachment and separate successfully, would cast doubt on

The association of school phobia and death in the family may be fortuitous and may not be causally related, but it does seem to affect the prognosis when school phobia does develop.

one's ability to exist autonomously. Thus, failure to dissolve this pre-oedipal bond means failure of ego autonomy and implies ego dissolution.

The relationship of depression to separation of the infant from the mother figure had earlier been described by Spitz.¹¹ He described a syndrome occurring in infants in the second half of the first year of life at which time the infants were separated from their mothers for a period of three months or more. The infants lost their means of emotional support and therefore developed an "anaclitic depression" manifested by sadness, withdrawal, slowness of movement, loss of appetite, and loss of weight. This became very serious and actually had a high mortality with it. In addition to the high mortality, followup studies on these infants showed some retardation of development.

It is possible that in the cases of school phobia described in this paper, the feared loss of the mother figure was not only manifested by separation anxiety and school phobia, but also by an "anaclitic depression," in Spitz's sense. The fear of their own death which all these cases showed, may be a direct outcome of an "anaclitic depression." Thus, the feared loss of the mother figure on which to lean on or depend on, caused a feeling of vulnerability, manifested by their fear of their own death.

As a result of a number of studies,^{5, 6, 8} it has been postulated that the effects of early separation are hidden, and later re-

peated experiences of loss reactivate the processes originating in the earlier loss. Bowlby feels that studies reporting an association between childhood mourning and later depressive states are significant because of the similarity he discerns between grief and mourning in an adult and the despair phase of response to separation in an infant. He feels that the defensive detachment following the despair phase of childhood mourning precludes a healthy working through of grief in the child and later predisposes him to depressive reactions.

In the cases reported here, the association of separation anxiety, manifested by the school phobia in the child, and a death in the family were concomitant. The death tended to start the process of grief and mourning and in a circular fashion reactivate the feelings of anxiety associated with separation. The sequence of events was the exact reverse of the usual manner grief and mourning proceed.

There, as described by Bowlby,^{3, 4} the phase of protest, separation anxiety, is succeeded by a phase of despair, or grief. In these cases reported here grief occurs first, and then is followed by separation anxiety, manifested by school phobia.

It should be noted that the cases presented are mostly in the older age group which is associated with a poorer prognosis. The association of school phobia and death in the family may be fortuitous and may not be causally related, but it does seem to affect the prognosis when school phobia does develop. It seems fairly obvious that school phobia will not inevitably develop in every child when an actual death occurs in a family. Bowlby has felt that the effect of the mother's disappearance or death is related to a critical time in the child's development, namely from six months to three years.^{3, 4}

If the mother is absent in that period a serious characterologic effect may appear in the child. Nevertheless, it would be interesting to study children where death has occurred in the family and no school phobia develops. In this way the coping mechanisms can be better understood.

Summary

Six cases of school phobia occurring in adolescents ranging in age from 11 to 15 years old are presented. In all the cases there is an association of school phobia, an active or feared death in the family, and a fear of the adolescent's own death. Using the frame of reference provided by Bowlby, school phobia can be understood as failure to resolve the normal attachment behavior. Its failure becomes linked up symbolically with failure to exist as an independent person, resulting in a school phobia. The presence of an active death in the family does seem to affect the prognosis once a school phobia does develop.

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Eugene J. Faux, M.D.

Blaine Crawford, M.S.W.

Deaths in a Youth Program

The authors discuss eleven deaths that occurred in a series of 595 patients admitted to the Utah State Hospital Youth Program over a six-year period. They consider five of these deaths to have been preventable. Since four of these five took place among patients assigned to the same geographic unit, it seems reasonable to assume that they are related to staff attitudes and hospital living experiences.

It is well known that children who have sufficient problems to enter state hospitals have a higher than average death rate. They tend to be accident prone, abrasive and depressed. Since the beginning of the Utah State Hospital Youth Program six years ago, records have been kept concerning all deaths.

This paper will discuss the reasons for these deaths and the possibility that some of them could have been prevented.

This program is the only residential treatment program for children in the state and as such has admitted 595 patients over the six-year period. These children were grossly decompensated and were usually not admitted unless local community services had been exhausted.

During this time children were required to live on the adult wards, which were divided into the geographic unit system. Each unit had its own professional staff, attendants and two to four wards.

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Eleven deaths took place—five during hospitalization and six after hospitalization. The causes ranged from a motorcycle accident to three suicides, one possible suicide and one murder. Unit I had two deaths, Unit II had one, Unit III had seven and Unit IV had one. Unit V, with the largest average daily census of young people and adults, had no deaths.

The youngsters in this sample, who ranged from age 13 to 19, had had their professional treatment and schooling in a day program separate from the rest of the hospital. All the hospitalized young people return at night to their respective wards on the adult units. Utmost cooperation is necessary between the two professional teams involved.

The authors will now take great liberties with this paper and record their subjective impressions in a general way as it concerned each adult unit, their attitudes about children and the type of experiences with the youngsters and staff.

Unit I

Interested in children, wanted to help, good staff rapport, permissive attitude, always available for conferences about children, some resistance to acting out patients.

Unit II

Positive attitude about children and a desire to help. Cooperative and available at all times, permissive in their approach. The children liked their dorm and staff. Worked well with acting out as well as withdrawn youngsters.

Unit III

Passive cooperation at first with gradual resistance and antagonism to children as responsibilities were felt. Intolerant of acting out patients and insisted only psychotics should be admitted. Antagonized the children and Youth Center staff. Boycotted staff seminars and when there rebelliously insisted that most mental illness was a myth. Finally refused to allow any children on their wards and the other units had to take care of them.

Unit IV

Cooperative and helpful. Positive most of the time. Had some of our most difficult cases to help with and did so without complaining. Permissive in approach. Available for conferences. Tends to resist acting out patients.

Unit V

This unit has a tremendous morale and handles the largest case load in the hospital. Responsibilities are taken religiously with children, even volunteering additional help or ideas. The children feel they are on a good unit, but complain that the policies are restrictive. There is a discipli-

nary attitude and strong therapeutic community type program. Personnel work equally well with psychotic and acting out patients.

Discussion

After analyzing this particular series of deaths the authors have concluded that five of them were preventable. Case 1 was in Unit II. The other four were in Unit III.

Case 1

This was a 15-year-old mentally retarded boy who had been in the hospital several years before the Youth Program began. He was taken for granted as a long-term problem and yearly physical examinations were not done. He never complained and took care of himself without much assistance. One day in the shower room an attendant noticed he had a large testicle which proved to be very malignant and the cause of his death.

... one night (he) hanged himself after making numerous threats to do so. He had been regarded as a ... nuisance who made frequent suicide gestures, but, who seemed unlikely to harm himself seriously.

Case 2

This 14-year-old girl was in the hospital several months before the Youth Program was initiated. She came from a broken home, having been deserted by her mother in infancy. She failed to prosper after almost a year's hospitalization. The father and stepmother made it plain they did not want her back in their home. At this point her natural mother appeared at the hospital, having lived all these years in an-

other state. She requested the patient's release, saying she was financially successful and capable of assuming responsibility for her daughter. The father at first objected but later joined his ex-wife in requesting the patient's release. Since she was a voluntary admission she was discharged. One and one-half years later we learned she had hanged herself in a girl's reformatory in the mother's home state.

She was a treatment failure in our institution and we hopefully and naïvely felt she could adjust when reunited with her mother.

Case 3

This boy came from a broken home, and experienced severe rejection by both of his parents. After unsuccessful private care he was admitted to the Utah State Hospital Youth Program but persuaded the judge to release him when he had his hearing. One and a half years later he was admitted as an adult patient making suicidal threats and cutting himself. He could not get along in the hospital and one night hanged himself after making numerous threats to do so. He had been regarded as a poorly motivated antisocial nuisance who made frequent suicide gestures, but, who seemed unlikely to harm himself seriously. Very few precautions were taken and supervision was lax.

Case 4

This girl was admitted at age 10 when Child Welfare workers claimed she had exhausted her foster home and school. She seemed to only be antagonized by hospital-

ization but failed also to adjust when another foster home was tried. On her second admission her regular unit would not accept her and she was transferred to another ward. She and another female teenager went AWOL claiming to have had a sexual escapade with boys they picked up. They called the police afterward and asked to be returned to the Hospital. Subsequently the program for her was restrictive. One night after a temper outburst she was found hanged by a sheet in her seclusion cell.

Case 9

This 19-year-old epileptic girl was extremely paranoid and abrasive. She could never prosper in the Hospital and seemed to go from bad to worse. She was found dead while at home on a trial visit and had taken an overdose of barbiturates.

Psychiatric treatment was a complete failure and she expressed hatred for the Hospital.

Conclusions

Four, and possibly five, of these cases were suicides. Since they were assigned to the same geographic unit and since no other unit in the Hospital had this difficulty it seems appropriate to relate these tragedies to staff attitudes and hospital living experiences.*

*The authors are currently working on a study to further identify living problems for our children as they occur in our Hospital. A later publication will define the social static on the respective units in a less subjective fashion.

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Dogmatism, Religiosity and Mental Health in College Students

Data of this study were used to test the hypothesis that the more dogmatic an individual is, the less secure he is. Ss were 166 lower division students at a small denominational university who completed the MMPI and the Dogmatism scale and who also provided information on their religiousness. The hypothesis was supported for religious females but not for males; in the latter group, it was found that high dogmatism scores were associated with "mentally healthier" scores on the MMPI scales of Hypochondriasis, Psychopathic Deviate and Schizophrenia.

In his seminal work, *The Open and Closed Mind*, Rokeach³ reported a significant positive relationship between dogmatism (as measured by his scale) and anxiety. The relationship, however, did not prevail in all samples—thus, religious subjects who were dogmatic were also anxious, whereas advocates of authoritarian political beliefs who scored high on the D (Dogmatism) scale were low on the anxiety measure. All subjects were college students; the politically dogmatic Ss, how-

ever, were in attendance at English institutions while the religious Ss were Americans. The speculations offered by Rokeach to account for the discrepant findings are not germane here; Rokeach proffered the explanation that religious beliefs may not be effective as an "anxiety reducing agent."

Rokeach's postulated relationship between dogmatism and anxiety received support in the investigation by Korn and Giddan¹ of the construct validity of the Rokeach D scale. These investigators found a significant negative correlation between D scale scores and the California Psychological Inventory (CPI) Well-Being scale scores, (Ss were 195 male college freshmen); they state that the correlation

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indicates that "... the more dogmatic an individual is ... the less secure he is." It should be mentioned that the religiosity of the college students was not a variable of interest in this investigation.

For religious females, however, dogmatism does appear to be negatively associated with mental health.

The purpose of the present study was to re-investigate the relationship of dogmatism, religiosity and mental health in lower division college students. The results appear to be sharply at variance with the Rokeach³ and Korn and Giddan¹ findings and cast doubt on the unqualified hypothesis that dogmatism is inversely related to indices of mental health in college students.

Procedure

The following data were obtained from 166 freshman and sophomore college students: Dogmatism (D) Scale scores; MMPI scores (in raw form) for the 10 standard clinical scales, three validity scales (L, F and K) and Anxiety (A), Repression (R) and Ego Strength (ES). Subjects also responded to questions regarding their church affiliation and whether they considered themselves to be religious or non-religious. The data were collected as part of another investigation.² The MMPI scores were used to provide measures of mental health.

Since there are sex differences on the MMPI scores in raw form, four groups were initially defined: Religious females (N=78), Non-religious females (N=21), Religious Males (N=45) and Non-religious males (N=22).

A correlational analysis revealed several significant associations between the D scale scores and certain of the MMPI variables. Therefore, all four groups of Ss were further categorized as low or high dogmatic (divided at the median) and the groups were compared using the MMPI scales as the dependent variables.

Results

Males

The findings of the comparison between high dogmatic and low dogmatic religious males are certainly in conflict with those of Rokeach and Korn and Giddan. The more dogmatic religious males scored significantly lower on three MMPI clinical scales: Hypochondriasis, Psychopathic Deviate and Schizophrenia.

Females

Korn and Giddan did not address themselves to the relationship of dogmatism and psychological well-being in female college students, but Rokeach's conclusions apparently hold both for males and females. For the religious females in this study, the more dogmatic the subject is, the more depressed, the more psychasthenic and the more anxious she is (although this latter relationship is three hundredths of a point removed from statistical significance).

Discussion

That the findings *vis à vis* the religious males in this investigation are not in accord with the statement: "... the more dogmatic an individual is ... the less secure he is" appears evident. It is difficult to accept a position that higher Hypochondriasis, Psychopathic Deviate and

Schizophrenia scores are indices of "security" or "well-being"! For religious females, however, dogmatism does appear to be negatively associated with mental health.

The difference in results may possibly be accounted for in a number of ways; for one thing, the MMPI, the CPI Scales and the scale Rokeach used as an index of anxiety provide differing measures of personal and social adjustment. Also, scholastic aptitude is a variable of influence, and such data were not available on our subjects. In this connection, it should be noted that Korn and Giddan found a significant inverse relationship to exist between both verbal and quantitative aptitude and dogmatism in males; for females, they found only the negative correlation between verbal aptitude and dogmatism to be significant. Finally, religiosity of the Ss was not a variable in the Korn and Giddan study and the extent to which this may account for the discrepant findings between our study and theirs is not known.

It would, however, appear safe to conclude that Rokeach's assertion that religiosity may not be effective as an "anxiety reducing agent" warrants re-investigation, at least in male college students; our data support the Rokeach hypothesis only for religious dogmatic females. In fact, continued investigation of the relationship between dogmatism and mental health along with the study of a variety of contingent factors might have considerable theoretical as well as practical significance for mental health professionals in university settings.

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Alex D. Pokorny, M.D.

Correlating the Fifteen Indices with Hospital Achievement Awards

Fifteen Indices¹ was a publication designed to bring out the relative standing of the states in support of mental health programs. The general goal was to help in obtaining adequate support for such programs. It was intended for use in public education, legislative hearings, and in self-evaluation by the officials and citizens of each state.

Fifteen Indices first appeared in 1957 and was reissued at two-year intervals until 1968. It is now under study for revision. We would expect that the states that scored high on the indices would be the ones with better programs, but this is difficult to judge without using the same items which make up the indices. One outside criterion which should identify quality in state mental health programs is the distribution of the American Psychiatric Association's Mental Hospital Achievement Awards² (recently renamed Hospital and Community Psychiatry Achievement Awards). These have been given for the past twenty years, thus overlapping completely the period during which Fifteen Indices was published.

This report presents a comparison of the states with respect to their standing in the Fifteen Indices and their numbers of Achievement Awards. The data published in Fifteen Indices for 1956 (in some instances 1955 or 1957) were used, because these

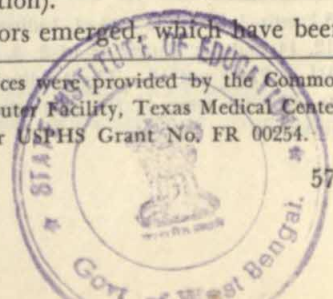
dates fall in the approximate midpoint of the 20-year Achievement Award period. Only the 48 contiguous states were studied, because data for Hawaii and Alaska were largely unavailable for that time. With regard to the APA Achievement Awards, the entire period of 1949–1968 was used. Only those awards which were given for state programs were included (omitting those for VA, city, county, private, and community programs not administered by the state). The total number of awards given to the 48 states was 52, including honorable mention awards. This is admittedly a small number for statistical manipulations, but this was the total number available. Initially a weighted system was tried, giving more credit for first and second prizes, but this turned out to correlate .98 with a simple count of numbers of awards. Accordingly, the latter was used in the calculations reported here.

The Fifteen Indices, as those familiar with this document will realize, tend to reflect related and at times overlapping items (e.g., "per capita general state expenditures" and "per capita general state and local expenditures"). Thus, it was decided to reduce the 15 indices to a smaller number of dimensions or groupings by the technique of factor analysis (principal axis with varimax rotation).

Three factors emerged, which have been

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labeled: I. "Advantaged Status"; II. "Understaffed, Low-cost Program"; and III. "Low State Government Spending." The 15 indices grouped readily into these three factors,* with high correlations or loadings.

Evidently some states manage to have well-staffed and well-financed public mental health programs even though they have only average general state spending levels . . .

The three factors were then correlated with the numbers of awards for the period 1949-1968, and with the population of each state as given by the 1960 census. One interesting finding was that Factors II and III had negligible correlations with total population (.09 and .05), whereas Factor I, "Advantaged Status," was significantly and positively related to population (product-moment correlation of .41). This indicates that the more populous states tend to be the more advantaged in such terms as income, numbers of psychiatrists, and expenditures for public mental hospitals.

It should be recognized, however, that the more populous states also have larger numbers of state mental hospitals and other state institutions and programs, and thus have more potential candidates for an award. Indeed, the number of awards during 1949-1968 was found to be correlated .45 with population, confirming that more populous states with more institutions receive more awards. This confounding influence of population was therefore removed by the technique of partial correla-

tion. As a result, the number of awards showed no significant relationship to Factor I (Advantaged Status) or Factor III (Low State Government Spending). The number of awards did, however, show a strong inverse relationship ($r = -.59$) with Factor II (Understaffed, Low-cost Program); the states which get awards for their state mental health programs are those which score low on this factor; that is, they are better staffed and have higher costing programs. The same relationships hold when the award period is split into two ten-year periods.

It is somewhat surprising that "Advantaged Status" shows no significant relationship after the effect of larger population is removed. Likewise, a low general level of state spending (Factor III) does not show any relationship to number of awards. Evidently some states manage to have well-staffed and well-financed public mental health programs even though they have only average general state spending levels, and they also manage to get their share of the awards.

It would appear, therefore, that at least some of the fifteen indices do indicate which states will receive more awards for innovative and outstanding mental hospitals and mental health programs; these are the items most directly related to staffing and funding of public mental hospitals. An incidental finding is that the fifteen indices are somewhat overlapping and redundant; they group readily into three factors or clusters of items.

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* Factor I is made up of Indices 1, 6, 7, 8, 11, 12, 14 and 15; Factor II of 2, 3, 4 and 5; Factor III of 9, 10 and 13. The loadings range from .66 to .95, and some of the correlations are negative (inverse).

Rudolph F. Wagner, Ph.D.

Secondary emotional reactions in children with learning disabilities

This discussion is based on the assumption, or willful suspension of disbelief, that disabilities in children do exist. It is further assumed that the learning disability is primary, and the emotional reactions to such disability are secondary in nature. The existence of primary emotional disturbances with symptomatic learning disabilities is not denied here. The subject will be approached on two levels: namely, (1) developmental psychological aspects of emotional reactions; and (2) possible remedial therapeutic efforts and techniques for treating these secondary signs.

Developmental Psychological Aspects

Before a youngster enters school he is usually a happy fellow even though he may potentially have a reading problem. The misery of the dyslexic child starts at the threshold of the school building! He will first try to fool the teacher by learning whole passages by heart since he is endowed with at least average intelligence.

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At the end of the first grade he will be in the lowest reading group in class. His reading is labored, words are omitted, consonantal clusters are reversed. Someone might have already called him a dummy.

This is the point where the secondary emotional reactions have their origin. The child reacts to continuous failure and to social ridicule by showing the first signs of an awareness that he is a failure. This reaction is provoked in two ways: first from within by affecting the budding self image; and secondly from without by being told about the poor performance. The emotional reactions are not specific to the learning disability but are the child's basic personality, only made more intense by provocation: the shy one gets shyer, the extrovert becomes aggressive, and the mildly anxious youngster may become phobic. Their reaction is expressed in hiding, avoiding or even denying the disability. An inferiority complex develops. The danger exists now that these gradually emerging emotional reactions may become permanently imbedded in the child's behavioral patterns, even after academic remediation has been instigated. They may become functionally autonomous.

However, the beginning of academic

remediation usually brings about a partial cessation of secondary emotional reactions. Four categories of emotional reactions can be discerned among those suffering from this agony as a byproduct of learning disabilities:

1. Defense and Avoidance Mechanisms, for example falsification of signatures, losing report cards, refusal to read, avoidance of books, etc.

2. Compensatory Mechanisms, such as developing behavior problems, foolishness in class, bragging, clowning while others read, or dressing up to the teeth.

3. Aggressiveness, either overt or covert, such as fighting on the yard, critical remarks, bothering others, making biting comments or throwing spitballs.

4. Anxiety and Withdrawal, behaviorally manifested in dependence, depression, daydreaming, regressive tendencies, or various fears.

The last two categories above may also develop into psychosomatic complaints with a variety of symptoms. Girls seem to be less affected by emotional reactions to failure than boys in the same way as the ratio of boys to girls is disproportionate (approximately 4:1). There are few children with learning disabilities, somewhere up to 10 percent, who show no emotional reactions, but this may well depend on the depth of the psychodiagnostic evaluation.

Remediation and Therapy

Treatment of emotional reactions to primary learning disabilities, if at all attempted separate from remediation efforts focusing on the academic disability, are available and may involve various techniques. Among the better known are:

1. Tutorial Relationship. Remediation procedures usually call for a small class environment and a 1:1 basis of teacher-child

relationship. It should be realized that this relationship is not only necessary for the conquest of academic deficiencies but seems to prepare the therapeutic conditions that are also conducive to the treatment of emotional reactions. This is of paramount importance with regard to the qualifications of the remedial or Special Education teacher who must be trained not only in academic remediation but also in counseling therapy.

2. Supportive Counseling. Counseling should be a byproduct of any academic remediation effort. It can be carried out by the school counselor or school psychologist in cases of mild-to-moderate severity. Supportive counseling is just as important for the child as it is for his parents.

3. Psychotherapy. In severe cases of emotional reactions, psychotherapy is indicated, usually provided by psychiatrists and well-trained psychologists.

4. Medication. At this stage, medication can be regarded only as a concomitant treatment, side by side with counseling or psychotherapy. Drug therapy still lacks the specificity needed to be directed towards specific symptoms. At best a child may be made amenable to treatment or remediation. The hyperactive may calm down more, or the anxious might be less apprehensive.

5. Behavior Modification. In recent years, operant conditioning techniques have been used successfully with all types of behavior, including learning disabilities. The technique may be carried out by the classroom teacher or parent, under supervision and after instruction from appropriate professional consultants.

6. Curriculum Modification. The subject of whether a dyslexic child should remain in the classroom or be isolated into special remediation groups is still controversial. However, one philosophy is

that the child should remain in the regular class where the non academic courses could be taught (physical education, art, shop, etc.), while the skill subjects would be offered in small groups, but in the same school, by qualified special teachers.

One of the assumed advantages here would be that the child remains with his peers, possibly lessening the severity of emotional reactions. On the other hand, the child may become more aware of his disability if he is isolated and may have to face social demands once he leaves the sheltered special class.

To this writer, the ideal solution—as yet far away from reality—is the amalgamation of child-oriented theories and task-oriented theories. A dyslexic child fights the language system; he is “normal” otherwise. If the given language system would not require left-right discrimination, consonantal blends, stringing of letters to make a word that stands for one idea—then he

would have a chance to beat the reading game in our culture. There is a clash between the human and the task system which must be overcome first. Our “normal” children seem to be able to read in spite of the clash of two systems. But a large percentage of children cannot cope with these incompatibilities between man and task systems. Something has to give before we can look for the breakthrough in special education. Some remedial methodologies for teaching reading have tried to make a dent into the dimensions of a task-system by altering the alphabet and orthography of a given language (e.g., “i.t.a.”, or Laubach), but at the end of the line the children taught by these methods face the cold reality of our English language usage: it is different from what was taught to them, and the moment of truth, the transition, has come. This is where failure once again may knock at the door of the “cured” disabled learner.

Law, Society and Mental Illness

Reprint from the January 1970 issue of MENTAL HYGIENE. \$1. Includes following list:

Community mental health and the criminal justice system, Shah;
Development of community mental health programs in the civil area;
Woloshin and Goldberg;

Titicut follies revisited: a long range plan for the mentally disordered offender in Massachusetts, McGarry;

New York's mental hygiene law—a preliminary evaluation, Zitrin, Herman and Kumasaka;

Who is competent to make a will?, Weihofen and Usdin;

A radical view of social welfare and mental health, Ginsberg.

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Robert Bellino, M.D.

Perspectives of Military and Civilian Retirement

This paper will attempt to compare and contrast some potential and actual difficulties in two large retirement populations—the military* and the civilian. Important areas of social and personal conflict and of potential psychopathology developed in coping with the stress of retirement will be indicated. A comparison of the organic health problems in military and civilian retirees will not be attempted here. It is hoped that the comparisons made will aid counselors and therapists in recognizing conflicts in adjustment of both the civilian and military retirees and in advising them accordingly.

Definition of Retirement

A precise definition of retirement or of its requirements exists neither for the military nor for the civilian retiree. Whether one is retired may depend on age, labor force participation, or physical and mental condition. Conditions of declining health and physical capacity usually are given as reasons for the need for retirement of civilians in the lower occupational statuses.

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In the military, and in a large segment of the higher civilian occupational statuses, withdrawal from the work force occurs because of a formal retirement system.

Only in the last several decades has civilian retirement emerged as a social pattern, while military retirement has been an expected termination of a career for a much longer period. In general, civilian retirement is considered to be an accrued benefit for the individual, serving to guard him against the difficulties of old age. In reality, retirement for both the civilian and military work forces is usually a consequence of institutional needs and interests.

For all retirees, retirement is an event which marks a turning point in their life histories. Retirement is both a status and a process for all individuals. Accepting a status of retirement can lead to stability and a realization that the individual will have a retirement status until death. The

* Many good sociological studies have dealt with the problems of the civilian retiree but none has dealt with the military retiree.¹⁰ However, several articles have recently appeared in medical journals describing a pre-retirement syndrome in military personnel.¹⁻⁸ We have recently published a paper for Florida physicians in which we attempted to define the post-retirement problems of the military retiree and offer suggestions for treatment.⁹

retirement process is the orderly transition from one period of life to another, leading to new interpersonal and social adjustment.

Financial Problems of the Retiree

At retirement the typical civilian retiree is about 65 years old. His children are no longer dependent on him—a fact which reduces the minimum income needed for subsistence. His retirement benefits usually consist of a pension which is intended to provide a reasonable measure of income, but which in fact provides only a minimum subsistence level.

Absence from home may have enabled the couple or family to adjust to or accept a relationship which under conditions of closer contact may be strained.

The military retiree is about 42 years old after a 20-year career. He generally has a wife and two or more dependent children, all of whom are accustomed to a certain prestige and standard of living. At the present time a chief petty officer with 20 years of service can expect to receive a retirement income of about 250 dollars per month. His financial and social expectations make his pension too small for retirement to be a leisurely period or an acceptable status. He does fare somewhat better financially than the civilian because he has access to added benefits such as completely free medical care and commissary privileges.

In America the social status of the family is often associated with the occupational position of the head of the household. In addition to status, our society largely defines success as money, activity, and youth. In our culture these factors are also intimately associated with work. The military

retiree maintains his youth, and financial needs necessitate continued employment with its concomitant activity. The need then for success i.e. work is a constant pressure on him.

The civilian and the military retiree are handicapped in finding employment as both are heir to labor market prejudices. Employers often prefer to fill positions from within their own ranks with younger men who have developed within the company. In addition, employers often feel that retirees can be hired at reduced salaries because of their retirement pensions. This supplemental income may further cause problems with unions and fellow employees. Unions often exert pressure on employers to hire younger men who have no retirement pensions. Fellow employees may harbor resentment against the retiree and envy the extra income which supplements his salary. The military retiree is further handicapped by the fact that some of his skills cannot be carried into the civilian labor market, and he often lacks employment information which might aid his integration into the labor market.

Interpersonal and Social Problems of the Retiree

Community acceptance, social status, and residence are areas of conflict for the military retiree immediately on retirement. The civilian who has community roots and retains the same friends and social ties does not experience so disruptive a change.

In a 20-year military career, the careerist, often accompanied by his family, has had six to eight separate assignments in many geographical areas where he had no intention of living permanently. He has been unable to develop lasting ties with any civilian community, with its social groups, established neighbors, churches and

schools, which might ease the changeover to civilian life.

Few professions or occupations throw individuals and families into such close social relationships with colleagues as does military life. Very quickly families learn that rank has privileges and provides a ready made social position. The serviceman and his family incorporate the value system to which they have become accustomed. As retirement approaches, the family and the retiree feel the impact of the loss of a way of life that has proved secure and satisfying. Then, unlike the civilian family, they must search and find a completely different social position in a new subculture that provides even fewer guidelines for them than it does for the retiring civilian family who do not have to so completely reorganize their lives.

Civilian and military retirees have a similar problem in the extra amount of time they will initially spend at home. Absence from home may have enabled the couple or family to adjust to or accept a relationship which under conditions of closer contact may be strained. At retirement, interpersonal relations must be extended by at least eight hours each day. This adjustment may be more of a problem for the military family, as military commitments have often separated them for extended periods. Even when the military retiree finds employment he spends relatively more time at home than ever before.

The military retiree has no counseling either verbal or written except in the area of financial benefits.

The wife, due to her husband's absences, may have learned to be the decision maker—a role she may not wish to or know how

to relinquish. Finding himself without the usual means of self-expression through work, the civilian or the military retiree may elect to express himself in a situation in which the available role is already well filled by his wife. He may try out a new role at home as homemaker, advisor, or head of the household. This period of adjustment is particularly stressful for the retiree who needs the support of a good marital relationship. Attempts at usurping his wife's responsibilities expose the retiring person to his spouse's hostility at a time when his defenses may be weakened by role confusion and by the loss of social status. The difficulties of this period are especially acute for the military retiree who is seeking a totally new self expression.

Counseling Problems

Counseling services, although limited in scope, are available to some civilian retirees. However, industries employing large numbers of workers are avidly seeking a more meaningful psychological and sociological approach in counseling their retirees. Currently, information on finances, physical and mental health, use of leisure, and geographical relocation is available at retirement. Even with its limited availability, this interest in the civilian retiree's future welfare tends to focus his attention toward planning for a meaningful retirement.

The military retiree has no counseling either verbal or written except in the area of financial benefits. One reason for this lack of information is that, until recently, the military's attention has not been drawn to the adjustment problems of the retiree before and after retirement. The retiree often makes his own plans. Employment and relocation are the main foci of his planning and the lack of counseling may allow him to assume that no particular

social or personal difficulties are anticipated for him.

Comment

In psychiatry, prevention of mental illness has only recently gained impetus. Unlike other areas of medicine where clear cut disease entities can be isolated and studied, in mental hygiene difficulty arises because causality and precursors of signs and symptoms of emotional illness have not yet been thoroughly identified. Social parameters and their relationship to individual stress have not been defined in many areas of social interaction, which further complicates preventative measures. Community psychiatry, the field which has been implementing mental hygiene principles into programs of mental health, now realizes that to be truly effective, sociological and medical principles must be applied to any intervention techniques. We feel that the military retiree represents a relatively homogeneous subculture. The study of that subculture could cut across sociological and medical lines, and thus permit application of sociological techniques to a mental health model and implement a truly preventive hygiene movement. Seldom do we find such a large group of people with similar life histories and subculture to study social and personal conflict as we do with the military retirees. We may be able to clarify general trends in the civilian and military retirees by contrasting the attitudes and role changes in the two groups, thereby anticipating individual difficulties.

Summary

This paper attempts to highlight areas of conflict for retiring civilian and military

personnel. Comparing the military and civilian retirees, the former is considered unemployed. Differences in interpersonal, social and financial stresses are discussed, pointing out varying intensities of problems mutually experienced by the civilian and military retiree. The reasons for the need for further studies in retirement conflicts are discussed.

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Sven Lundstedt, Ph.D.

Conflict Management: Preeminent Challenge

Primary Elements in Social Conflicts

Social conflict cannot be understood without reference to the existence of at least two or more parties which may be individuals or, in a corporate sense, groups and organizations.

Conflicts can also exist within a person as conflicts of psychological motives and attitudes, including the behavior of the conscience. Individuals may be in conflict with themselves, but such a "personal" form of conflict usually arises with reference to a specific relationship with an external person or object. Conflicts of a personal nature are very often a significant event in social organizations. Moral conflict (conscience) or conflicts of thought and purpose will affect, often deeply, the outcome of social conflicts.

The Arena of Conflict

Kenneth Boulding¹ describes two elementary kinds of social acts which occur in any engagement with an adversary. They

are called *conflict moves* and *trading moves* respectively. Successful trading results in both parties gaining something. Conflict results in gains for at least one party and some losses for the other. Occasionally both lose. Mutual loss is a special outcome of conflict behavior in which neither party may have full control over a final outcome. Conflict always has a "win-lose" quality.

Fortunately, all conflicts are not irretrievably hopeless. Often they are changed into trading by such compromises as bribes and side payments. Negotiation and bargaining, strictly speaking, is a procedure by which a particular conflict field is explored to find the best available trading moves. But as soon as all available trading moves in a particular field of conflict are exhausted, the parties are left with an "irreducible minimum" of conflict. If the leftover conflicts are unimportant to the further survival of either party, each may lose interest. If the remaining conflicts are serious enough, the relationship between the two can become a crisis and deadlock. New methods of conflict management are then imperative. The "relevant states," or value systems, in the conflict field have to be re-examined to find ways to break the deadlock. But this analysis so far is still not enough.

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Attitudes and Motivation

Two psychological dimensions are also necessary to a further understanding of social conflict. Social attitudes is one and motivation the other. If we should ask why conflict and trading occur, other concepts would be required to help explain the *source of action*. Conflict and trading are *motivated* behaviors. The final objective of all motivated behavior in people (barring exceptional cases) is psychological and physical survival and the maintenance of optimum conditions for continuing growth.

All conflict and trading behavior can be said to be motivated by reward or punishment. Experimental research and common sense overwhelmingly support the interpretation that people are attracted by the promise of pleasure and the reduction of pain. On the other hand, pain irritates, angers, and then repels or provokes attack. But conflict and trading are also motivated by reasoning and reasoned choices among alternatives, especially in the selection of avenues for achieving personal or group goals which appear rewarding.

People, groups, or organizations can hardly be expected to bargain rationally even in their own interests in the face of hostile attitudes, mistrust, and anger that are aroused by mutual punishment.

Memory and Anticipation

We think about social relations not only in terms of anticipated future but also in terms of immediate and past memory (both emotional and intellectual) of earlier pleasure or pain. Conflict and trading behavior no doubt reflect the influence of long- and

short-term memories to a far greater extent than we may know at present. As for plans and anticipation, it is fair to say that most people regard the future in terms of a subjective probability wherein either winning or losing in a conflict is expressed along a scale of values in which long- and short-term memories of former reward and punishment play an important part. To argue that people, and ultimately groups and organizations, do not use reason in an effort to ensure for themselves and their groups a maximization of gains over losses is certainly a non sequitur. It is hardly logical to think that most sensible people are indifferent to their relative chances for survival.

Only when minimal human requirements for survival have been met can generosity and cooperation begin to take on concrete meaning. Paradoxically, though, under some conditions people may be able to express these sentiments even when deep dissatisfaction and personal suffering are evident. People can express humane, social wants and sentiments even under duress provided, of course, that too much duress does not exist.

Generosity also leads to reciprocity. George Homans² tells us that human social exchanges are a form of "economic" reciprocity.

Reward and punishment also markedly affect intellectual commitment. In trading, when one is consistently rewarded, thoughts about one's adversary should tend to become favorable. When two or more parties continue to be mutually rewarded the relationship between them eventually should improve.

Attitudes

When we think, feel, and prepare to act toward some one or some thing we are said

to have an attitude toward it. These three elements form the structure of a single attitude, and, thus, an aspect of our psychological posture. Thought, feeling, and a readiness to act are obviously of great importance in understanding conflict and trading behavior, and ultimately conflict management. In fact, we know a great deal when we know the true attitudes of another, and, accordingly, we can plan better by anticipating his intended strategies.

On the basis of this we can examine common mistakes and methods of confrontation.

Two Methods of Confrontation

1. *Dueling.* This method of confrontation has been inherent in generalized conflict, such as total war, where adversaries may lose heavily. The inevitable "win-lose" quality that arises in total war traps contenders in cycles of behavior that can lead to mutual destruction. Naturally, since each will work only in terms of his own self-interest and survival to the exclusion of the other, each may become irrevocably trapped within this behavior pattern. It is this particular blind alley that so decidedly helps to shape the final outcome of such conflict and sets narrow limits upon the opportunities that may become available for its resolution. People, groups, or organizations can hardly be expected to bargain rationally even in their own interests in the face of hostile attitudes, mistrust, and anger that are aroused by mutual punishment. Indeed the dilemma is a form of "conflict trap" often with no visible way out. For example, hostile duelers often cannot abandon a pattern for fear of loss of face, status, or property.

Paradoxically, a limited war may represent only a slightly improved form of con-

flict management. True, it is quantitative deescalation, but it is not a qualitative deescalation as a rule.

The psychological limitations of this method of social problem solving are qualitatively the same as those in total war. Threats to survival inevitably force contending parties to adopt the inexorable logic of defense and offense. The locked-in quality of the "win-lose" frame of mind strangles efforts to find avenues for productive bargaining, and the cycle of dueling and mutual destruction remains essentially unchanged.

II. *Mutual Problem-Solving.* Modern so-called collective bargaining attempts to break a *qualitative* barrier in dueling behavior because it reflects a change in attitude and in the motivational bases for action. The legal requirement of negotiation in many modern conflicts has set the stage for mutual problem-solving leading to intelligent trading behavior. The special conditions for such an outcome involve not only a conscious effort to abandon open hostile dueling but the emergence of mutual trust. But we may ask, what in addition to mutual trust is the major difference between such problem-solving and the other patterns of conflict management? What can one expect to find in this pattern and not in the others? Initially, the motivational basis of conflict management has changed from mutual punishment to mutual reward wherein the cultivation of positive attitudes toward one another is seen as valuable and necessary in its own right.

Management of Threat and Anxiety

Control of threat and of increased anxiety is an initial qualitative difference in mutual problem-solving. Anxiety has not always been correctly interpreted. At times

it has been called an unnatural element in behavior, an interpretation formed no doubt from clinical observations of its dysfunctional aspects and their effect upon personality. Such a limited interpretation has evidently narrowed its usefulness, for it fails to acknowledge the genuinely natural function of anxiety.

In moderate quantities, anxiety is a very effective energizer and motivator. As it increases, however, it tends to destroy the capacity to reason efficiently and thereafter acts to inhibit flexible, creative thinking, replacing it with impulsive flight or fight behavior.

This is why excessive threat is a potent negative force in conflict management, and may limit one's capacity to use effectively the bargaining strategies available. The indiscriminate use of threat is dangerous at best. There are many forms of it, and no matter how eloquently it is expressed, one can never be sure just *how much* anxiety and impulsive behavior a given form will produce in an adversary.

Negotiation involving the core resources of a person, group, or organization is less likely to result in fruitful trading behavior because of its threatening nature.

The alternative to threat of any kind is that form of behavior which succeeds in reducing anxiety by providing evidence of positive concern for the survival of one's adversary.

Anxiety is a form of "noise" in human communication. In its loudest forms it will destroy listener and communicator effectiveness. Since bargaining and trading depend upon good feedback they will be affected adversely by the loss of it caused by defenses against anxiety. This, of course,

eventually will leave only blind conflict and further dueling as an alternative form of exchange.

Capacity for Taking Interpersonal Risks

A second qualitative difference is a willingness to take risks with other people, which is a basic element in trust. Interpersonal risk³ is a formulation which argues that people will withhold or give away personal influence and control over one another (share and exchange resources) only after an initial assessment by them of the amount of personal risk involved in such a relationship. The concept of interpersonal risk may be applied to the group or organization one may represent. When the capacity to take interpersonal risks is inhibited by too much anxiety, negotiation toward higher forms of agreement is circumvented.

Other Advances

One advance is positive face-to-face confrontation. Fruitful negotiation is impossible among human beings by remote control. People require the constant reassurance of others' intentions by personal contact.

Dueling confrontations, unfortunately, are often not fruitful for the several reasons already given. They are familiar today as extremist responses to frustration on our campuses and in our communities. Eventually, some form of rational bargaining and compromise is necessary among even the most hostile adversaries.

Another advance is to establish a policy of improving trust by reducing threat and, subsequently, the inevitable human responses of anxiety, frustration, hostility, and defensive behaviors of flight or fight

associated with threat and anxiety. A good treaty is one special form. Another is to examine freely and with candor mutual goals and all available paths to such goals. All parties require accurate information about areas of mutual gain and agreement, as well as areas of legitimate differences. Still another is deliberate disengagement from old patterns of language and thought. Language and other cultural patterns can be serious barriers to effective mutual problem-solving.

A Final Step: Avoid the Most Valued Commodities

The intellectual and material resources of any person, group, or organization are usually ranked in terms of their survival value. Accordingly, as one bargains with the most precious elements of any social system, the price of a trading exchange will naturally be higher than for less precious elements. A price may be too high to allow trading if the things to be exchanged are too precious. At such a point normal further trading may become a threat and a conflict. To press one's advantage may convert a free exchange into a "win-lose" situation. An adversary will, as we have seen, respond with defense or offense if his capacity to survive is threatened. Negotiation involving the *core resources* of a person, group, or organization is less likely to

result in fruitful trading behavior because of its threatening nature.

Should the strategy of conflict management one adopts initially begin at the periphery of a group's valued resources? Our knowledge of human behavior suggests it might best begin there. Where one stops in trading and negotiation is a pragmatic matter guided by one's awareness of natural human boundaries which eventually become known. They have often been called "territorial imperatives" indicating that they are functional borders and frontiers which are there to assure survival. Consequently, empathy toward others is decidedly a cornerstone in negotiation and bargaining.

The critical nature of modern social conflicts (war, race, labor-management, for example) in a densely populated, interdependent world requires a continuing reassessment of conditions and needs and increased effort in the search for an improved method for effective conflict management.

REFERENCES

1. Boulding, Kenneth, A pure theory of conflict applied to organizations, in, Kahn, Robert L. and Boulding, Elise, *Power and Conflict in Organizations*, New York: Basic Books, 1964.
2. Homans, George, Social behavior as exchange, *Amer. J. Sociol.*, 63:597-606, 1958.
3. Lundstedt, Sven, "Interpersonal Risk Theory," *J. of Psychology*, 62:3-10, 1966.

On Helping The Disadvantaged

On May 4, 1968, the Board of Directors of the National Association for Mental Health adopted a statement of policy with respect to the Association's activity in behalf of the disadvantaged. In brief, it committed the Association to giving special emphasis to the needs of the poor and other disadvantaged in all program areas.

It is obvious that it is considerably easier to adopt such a policy than to implement it. A number of reasons are apparent:

Most people don't know how to help those who are different from themselves. No white person in the United States has known the effect of discrimination because of skin color. In the same manner, affluent people, of whatever color, don't know or forget if they once knew, what it is to be poor. Thus, for one or both reasons, many well-meant efforts to help fail because the help was of little or no real benefit to the person helped. Too, the problem of poverty is so deep and complex that it sometimes seems completely hopeless—as if the problem of mental illness were not bad enough in the first place.

There is a tendency to confuse the aims of help—to try to make other people over in one's own image. There is no reason that an Indian or Mexican-American or Negro should give up his culture and take on the trappings of white middle class America in order to be rescued from poverty or discrimination. Yet, too often, ef-

forts at assistance are directed in this manner.

Such things can be overcome; but, there are other, more disturbing impediments.

Too often the helpers are patronizing—they make the person being helped so aware that he is being helped that he is held down or turned away by the very process of being helped; or proprietary—the helpers seek to own the people they are supposed to help.

Some people want to help others as a generalized group at a distance, yet are embarrassed or bothered by, or balk at, dealing specifically with individuals from that group.

Finally, there are those who climb on the bandwagon without ever intending to do much or keep finding new bandwagons. And, unhappily, there are those who either moralistically or selfishly don't want to see change.

These things are not limited to the mental health association. But they can defeat our expressed desire to give special help to the disadvantaged—and they can defeat us in achieving our broader goals with respect to mental illness. Nor is there any certainty that they will be overcome. It remains for each individual, and the group of which he is a part, consciously and deliberately to see to this.

Among the items enumerated in the Board's statement was a call for the presi-

dent to assemble a committee of advisors from among those most knowledgeable and involved in the areas of poverty and disadvantage to advise on implementation of the policy. This has been done.

The committee has proposed that, by appropriate by-law changes, at least 20% of all boards and communities of the Association, at all levels, be economically disadvantaged persons or members of minority

groups. It is anticipated that this recommendation will be submitted to the membership at the Association's Annual Meeting in November, 1970.

Whether or not the proposal, as presented, or in some modified form, is adopted, or is an appropriate means of implementation of the policy with respect to the disadvantaged, the policy itself and the commitment it contains will remain.

JAMES E. CHAPMAN

NAMH ANNUAL MEETING

Focus—Prevention

Los Angeles, November 16–21, 1970

Opening session 5 pm Nov. 18

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NAMH Position Statements on Family Life and Sex Education and Marriage Counselors

The following position statements, written by the NAMH Professional Advisory Council, were adopted by the NAMH Board of Directors on June 20, 1970.

FAMILY LIFE AND SEX EDUCATION

The Mental health implications of family life and sex education programs are self evident. Examination of the current scene as it affects young people, parents and families as well as the community at large, with all its attendant suffering, leaves little doubt about the need for responsible, relevant and effective education programs in family life and sex education. Indeed, it is one of the most practical mental health issues upon which a position can be taken. In supporting such, NAMH joins an impressive list of major educational, religious, medical and health organizations throughout the country who are endorsing responsible family life and sex education.

The increasing controversy surrounding the introduction of family life and sex education programs in public schools has extended itself to a degree where it poses a serious threat to this essential aspect in the health education of children and young people. Responsible programs directed towards improving knowledge about this critical phase of human development as well as bettering understanding between young people and their peers, young people and adults, are being subjected to strong opposition stemming from a variety of sources.

The primary source of family life and sex education should be in the home. For a variety of reasons, evidence indicates that

in many, if not most instances, children do not receive this type of essential information given in a comfortable, accurate and relevant form by their parents. Presentation of this essential component of health education under public educational auspices requires especially the participation (i.e. sanction) of parents not only to endorse such programs, but also to share in the matter of material to be presented, when and how such will be carried out and who shall teach the matter. Family life and sex education programs without this essential contribution of joint participation by parents and educators are subject to misunderstanding, suspicion, attack, and early failure.

In addition to the parent role and effective pedagogical techniques including special teachers, family life and sex information programs require the support of a variety of helping agencies and individuals. Mental health organizations with their awareness as to the importance of these matters have an unusual opportunity to support and aid in the direction of family life and sex education programs in cooperation with other appropriate groups. A considerable number of national, state and local organizations have developed program materials or actual programs which may be useful to local mental health associations in their role as a resource group

to a community's effort to develop an appropriate program in family life and sex education.

It is recommended by the NAMH Professional Advisory Council that the local professional advisory committee of the mental health association be consulted when the Association considers programming in this field.

REFERENCES

Sex Information and Education Council of the U.S.
1855 Broadway, New York, N.Y. 10023

Guidelines for Developing School Programs in Sex Education

New Jersey Department of Education
225 West State Street, Trenton, N.J. 08624

Family Life and Sex Education Course Outlines
for Grades Seven Through Twelve
Anaheim Union High School District
1765 West Cerritos Street
Anaheim, California 92805

American Medical Association
535 North Dearborn Street, Chicago, Illinois 60610

Family Service Association of America
44 East 23rd Street, New York, N.Y. 10010

Family Life Literature and Films—an annotated bibliography
Minnesota Council on Family Relations
1219 University Avenue, S.E., Minneapolis, Minnesota 55414

STATEMENT ON MARRIAGE COUNSELORS

With the current state of knowledge, it is difficult to be definite as to the qualifications for marriage counselors. Far more research is needed to learn what constitutes effective intervention and to identify what skills are necessary to that process.

We do know that serious marital disharmony often gives rise to or is symptomatic of significant emotional upset. This clearly indicates that the person providing formal marriage counseling should be related to a broader system of mental health care.

We are also strongly persuaded that it is premature to think of marriage counseling as a separate profession or discipline. The issue of whether a person is qualified to deal with the emotional crisis of marital discord begins with whether the person has been trained to intervene in emotional crises in the first place. One is not a marriage counselor *per se*.

The qualifications for marriage counseling, as currently described by the American Association of Marriage Counselors, seem to us to provide a reasonable test of whether

a person might be equipped to provide marriage counseling. That organization holds that counselors should, in the first place, be fully qualified to practice the profession in which they achieved their original graduate training. A minimum of a Master's degree in social work, an M.D., or Ph.D. in psychology, sociology or a closely related field, a B.D. or other recognized three-year graduate degree from a theological seminary is required. For such persons, an additional year of clinical internship followed by a period of three years of professional practice is recommended.

For those wishing additional information, we attach a background paper used by the Professional Advisory Council in developing this statement. (*Available on request*)

It is recommended by the NAMH Professional Advisory Council that the local professional advisory committee of the Mental Health Association be consulted when the Mental Health Association enters into discussion about the issue or into any form of local evaluation and action.

Book Reviews

A Time to Heal: Corrective Socialization—A Treatment Approach to Childhood Schizophrenia

By William Goldfarb, M.D., Ph.D., Irving Mintz, M.S.W. and Katherine W. Stroock, A.B.

New York, International Universities Press, 1969. 148 pp.; \$5.

There are perhaps few areas of clinical concern that are more clouded by conflicting theories of etiology, course and treatment than that of childhood schizophrenia. Since 1953, the Ittleson Center for Child Research has been engaged in research and treatment of children designated as schizophrenic. In *A Time to Heal*, Dr. William Goldfarb, director of the Center, Irving Mintz and Katherine Stroock present their views on the educational correction of the functional deficits shown by these children. In their view, the objective of treatment is to stimulate the growth of absent or deficient function by constantly exposing the child to a series of sensitively handled experiences. The authors reject the view that "therapy" can be provided to the child once, twice or five times a week, in relatively brief encounters, and yet be effective. Rather, their aim is to provide a total milieu where the child is responded to with an active remedial attitude and with corrective experiences.

At the Center the children are treated by child care workers, teachers and their psychiatrists. In the major portion of the book, the treatment approach of the Center is presented by providing case illustrations followed by comment on the significance of the interaction between the worker and the child.

I must admit that I approached this book with considerable bias, having been trained largely from a learning theory point of view, and finished by being rather impressed by the straightforward commonsensical approach of most of the treatment.

For example, children who express fear of a counselor's departure are reassured and a child who is afraid of the fire in the boiler is told by her teacher, "Don't worry, I won't let the fire

hurt you", as she places herself between the fire and the child.

These and other such examples of common sense handling of aberrant behavior are refreshing when compared with Melanie Kleinian psychoanalysis, but rather commonplace for anyone who has worked with experienced special educators or nursery school teachers. Yet the authors suggest that it is only by understanding the psychoanalytic significance of the child's problems that corrective socialization can occur. The girl who was afraid of the boiler is said in truth to identify the boiler symbolically as her father, (why not her mother?) and fears the fire because of the sexual excitement she feels towards him. In my view, such speculative interpretation may fortuitously, or not, result in the proper action being taken, but may also inhibit teachers from acting in a common sense, spontaneous and direct manner.

As I read the psychoanalytic commentary I could not help thinking how easily the examples of corrective socialization could be interpreted equally with learning theory jargon. This, despite the author's criticism of "programmed schedules of reinforcement". For example, "One must respond to "normal" communications with interest (reinforcement)*, whereas symbolic and illogical productions are to be met with indifference (non-reinforcement) and, eventually, the withdrawal of shared pleasures (contingent consequences, punishment, etc.). With patience, and confidence in the rightness of the procedure on the part of the therapist, even a very bizarre child can move toward a more logical verbal communication and toward more socially acceptable behavior".

While I found many other little things in the book distracting, on the whole, it is worthwhile. Its lack of a statement of generalizable principles for working with severely disturbed children will restrict its use for mental health professionals. However, its presentation of sensitively and practically handled situations with the disturbed child, may prove interesting to nurses, child care workers and students of special education.

MARTIN GITTELMAN, PH.D.
New York, N.Y.

* (The bracketed comments are my own.)

The Encyclopedia of Human Behavior: Psychology, Psychiatry, and Mental Health

By Robert M. Goldenson, Ph.D.

New York, Doubleday & Co., 1970. 1,472 pp.; \$19.95.

One of the notable gaps in the education of both the general educated public and the youngster beginning to be interested in the behavioral sciences as a career, has been the lack of a comprehensible introductory guide. Young people—among the most gifted, too—like to browse for a while in a field that has begun to interest them. Browsing in the field of human behavior, until one has achieved a certain level of sophistication, is a difficult undertaking. One may ingest a good deal of nettles, Jimson-weed and sundry other indigestibles as well as more solid fare.

Now Dr. Goldenson comes along to remedy this situation and has succeeded beyond any reasonable expectation. Probably not since Tuke's remarkable work of 70 or 80 years ago have we had anything quite like it. It is what the French would call a triumph of *haute vulgarisation*. Here is a remarkably broad coverage of those areas of human behavior which preoccupy the behavioral scientist at the present time, presented in a pleasant and unobtrusive prose.

The author has been kind enough to thank the reviewer for some tiny service he rendered during the book's gestation, but my gratitude does not, I think, sway me by itself in the direction of approval. If I were looking at the articles contained herein from the viewpoint of a professional, I am sure that I would fairly often find areas within my own competence, that are rendered as somewhat simpler than reality. However, if I put myself back in time to the period at which I was wondering about a career in psychiatry, these volumes would have been a remarkable pleasure to come upon. The reader whose needs lie in obtaining simple but accurate information about complex and jargon-filled subjects, has no better resource at his disposal. It is not, of course, by itself a major resource for the professional but I suspect that many of us will consult it surreptitiously in order to find out what on earth *Time* magazine

is talking about in its latest column on behavior. It might keep us a step in advance of our increasingly well-informed patients.

I am rather sure—this takes no great prophetic skill—that some professionals will review these volumes in a highly negative way; but they will miss the point. The point is that we have badly needed for a long time a *good* summary of modern theory and practice suitable for the layman and the beginner. I think we have it now. I think most mental health associations would find this a useful addition to their libraries. So, too, would school libraries at every level.

DONALD P. KENEFICK, M.D.
Dean, New York School
of Psychiatry

Everything You Always Wanted To Know About Sex (but were afraid to ask)

By David R. Reuben, M.D.

New York, David McKay Co., Inc., 1969. 342 pp.; \$6.95.

It had to happen sooner or later, the Everyman's Guide to Sex. Perhaps only a California psychiatrist could have produced this highly readable, entertaining volume that tells you everything you would want to know and more.

The author has a non-judgmental, folksy approach to every conceivable (no pun intended) problem, although he does reserve the usual psychoanalytic "sick" label for homosexuals and will undoubtedly be on the Gay Liberation blacklist for some time to come.

It's possible to quibble over a few facts, and many reviewers have, especially in the area of homosexuality. But, much of the information is sound. If the basic information could only be relayed to those who so bitterly oppose sex education, Dr. Reuben will have performed a lasting service.

JOHN DORAN, M.A.
Philadelphia, Pa.

BOOKS RECEIVED

Because of space and time limitations, we cannot review all the books we receive. The listing of such books in this column must be considered acknowledgment of the receipt of the volumes indicated. As space, time and subject matter permit, we will publish full-dress reviews of the more significant books on the areas of interest of our readers.

BEHAVIORISM. By John B. Watson. New York, W. W. Norton & Co., Inc., 1970. 308 pp.; \$1.95, paperback. Yes, this is the classic work, now in a handy paperback edition.

CHANGING HOMOSEXUALITY IN THE MALE. By Lawrence J. Hatterer, M.D. McGraw-Hill Book Co., 1970. 492 pp.; \$15. Case histories, transcripts of therapy sessions and explanations of treatment methods make up this book. Dr. Hatterer draws on experience in treating more than two hundred homosexuals over the last seventeen years.

CLIENTS OR CONSTITUENTS. By Neil Gilbert, Ph.D. San Francisco, Jossey-Bass, Inc., 1970. 192 pp.; \$7.75. The author analyzes an anti-poverty program in Pittsburgh to determine the dynamics involved in increasing the influence of poor people upon the institutions that serve them.

THE COMMON BASE OF SOCIAL WORK PRACTICE. By Harriett M. Bartlett, with the assistance of Beatrice N. Saunders. New York, National Association of Social Workers, 1970. 224 pp.; \$4, paperback. This is an overview of social workers' ways of thinking about their practice.

THE DESIGN WITHIN: PSYCHOANALYTIC APPROACHES TO SHAKESPEARE. By M. D. Faber. New York, Science House, 1970. 551 pp.; \$13.50. The author has gathered essays on the psychology of Shakespeare's works (three by Freud) and added his own evaluations of them.

DYNAMIC PSYCHIATRY IN SIMPLE TERMS. By Robert R. Mezer, M.D. New York, Springer Publishing Co., Inc., 1970. 179 pp.; \$3.50, paperback. Readable textbook, now in its fourth edition, revised to reflect the changes in nomenclature of the Diagnostic and Statistical Manual of Mental Disorders.

EXPERIENCING YOUTH: FIRST PERSON ACCOUNTS. By George W. Goethals and Dennis S. Klos. Boston, Little, Brown and Co., 1970. 399 pp. paperback. This book presents cases, written by young people, that illustrate aspects of the psychology of adolescence.

HEALTH IN THE MEXICAN-AMERICAN CULTURE. By Margaret Clark. Berkeley, University of California Press, 1970. 253 pp.; \$2.45, paperback. Even though

it is a second edition of a study first published ten years ago, the problems of health care have not changed much.

HELP ME! By Lu Etta C. Al-Saadi, M.S.W. and Dorothy Goos, M.S.W. Kaukana, Wisconsin, Thomas Publications Ltd., 1970. 383 pp.; \$18.75. Group living therapy approach to helping adolescents.

HOW TO LIVE WITH YOUR SPECIAL CHILD. By George von Hilsheimer. Washington, D.C., 1970. 272 pp.; \$7.50. Using behavior therapy, Rev. von Hilsheimer has set up a residential school for difficult children. He discusses his theories of education and administration.

INCENTIVES TO WORK. By David Macarov, Ph.D. San Francisco, Jossey-Bass, Inc., 1970. 253 pp.; \$8.75. Why has the richest country in the world been unable to wipe out poverty? The author suggests that it is our fear that providing the poor with a decent living will ruin their incentive to work, thereby allowing them to do what many of the nonpoor secretly wish to do—live a life of leisure. Dr. Macarov examines the American attitude toward work and disproves the theory that men will stop working if given unearned income.

NEW UNDERSTANDINGS OF HUMAN BEHAVIOR. Edited by Harold D. Werner, M.S.W. New York, Association Press, 1970. 286 pp.; \$7.95. Billed as a "frontal attack on the Freudian and neo-Freudian Establishment", this is a collection of articles from professional journals that span the period 1960-68.

PET-ORIENTED CHILD PSYCHOTHERAPY. By Boris M. Levinson, Ph.D. Springfield, Illinois, Charles C Thomas, 1969. 202 pp.; \$9.75. Even those who aren't interested in the use of pets with emotionally disturbed children will enjoy reading about the psychology of animals and of man's involvement with them.

THE PREVENTION OF DRINKING PROBLEMS. By Rupert Wilkinson. New York, Oxford University Press, 1970. 301 pp.; \$10. This book grew out of the work of the Cooperative Commission on the Study of Alcoholism. It outlines methods to influence the "climate" of drinking, which, Wilkinson believes, is a powerful factor behind problem drinking.

THE PSYCHIATRIST AND PUBLIC ISSUES. Formulated by

the Committee on International Relations, Group for the Advancement of Psychiatry. New York. GAP Publication No. 74, 1969. 25 pp.; \$1. Outlines basic considerations that a psychiatrist must take into account when he becomes involved in public issues, both personally and professionally.

THE PSYCHOLOGICAL ASSESSMENT OF CHILDREN. By James O. Palmer, Ph.D. New York, John Wiley & Sons, Inc., 1970. 475 pp.; \$12.50. Textbook for the clinician.

PSYCHOTHERAPY AND THE DUAL RESEARCH TRADITION. Formulated by the Committee on Therapy, Group for the Advancement of Psychiatry. New York,

GAP Publication No. 73. Examines the conflicts that arise within the field of research.

SEX IN THE CHILDHOOD YEARS. Edited by Isadore Rubin, Ph.D. and Lester A. Kirkendall, Ph.D. New York, Association Press, \$4.95. A collection of articles on all aspects of sex education for children. Written for parents, teachers and counselors.

TWO CHILDREN BY CHOICE: The Why and How of the Two Child Family. Isadore Rossman, M.D. New York, Parents' Magazine Press, 1970. 151 pp.; \$3.95. In praise of voluntary family planning, this book discusses all aspects of the decision to limit one's family.

Film Reviews

Hospital (90 min., black and white, 1969) Produced by Frederick Wiseman. Distributed by Osti Films, 264 Third, Cambridge, Massachusetts 02142.

A documentary look at New York's Metropolitan Hospital becomes a commentary on some of the overpowering problems of society in Frederick Wiseman's latest film "Hospital". No commentator breaks the reality of the misery, fear and worry that weigh on the patients and staff; the only sounds are those recorded live by microphones at the scene.

Although filmed at a general hospital and depicting the problems and frustrations of general medical care to the poor, aged and others rejected by society, it goes much deeper than a mere comment on delivery of health services. It gives a penetrating view of many of society's wrongs. It vividly presents a society that forces a man to fear for his unattended children rather than for his health, a society that can find no place for a neglected child who has been left to the care of an alcoholic grandmother, a society that cannot provide welfare for a young, schizophrenic homosexual in order that he might financially afford to give up prostitution.

If Wiseman is cruel to society, he is the opposite to the medical professionals. He shows them as efficient and sensitive workers being forced to work under unbelievable conditions and make decisions no human being should be called upon to make.

"Hospital" has been shown on educational

television for general audience viewing. It could also be shown to specific audiences to sensitize them to the problems in delivering health services to the poor, on the one hand, and the problems of society that must be corrected before all citizens are allowed the right to good health, on the other.

Boys in Conflict (72 min., black and white, 1969) Produced by Dr. Edward A. Mason, Department of Psychiatry, Harvard Medical school. Distributed by Center for Mass Communication of Columbia University Press, 440 West 110th Street, New York, N.Y. 10025.

Camp Wediko in New Hampshire provides a unique living and learning experience for emotionally disturbed boys. This film was shot at the camp during a seven-week period and shows the development of both campers and counselors during that time. The main focus is on one counselor, Steve, and his cabin of nine boys. As the campers follow Steve, the viewers experience a "working through" of problems as they arise. Steve discusses many of his actions with other counselors and with professional staff in an attempt to understand the boys he is working with and to better understand himself.

The film is an excellent training film for staff working with emotionally disturbed children. It does not attempt to provide a documentation of an ideal treatment milieu; rather, it is one interesting and provocative glimpse of one means of treatment.

Pam Wilson, M.A.
Washington, D.C.

MENTAL HYGIENE

Publications from the National Association for Mental Health

Policy and position statements on:

- Abortion
- The Disadvantaged
- Family Life and Sex Education
- Insurance Coverage
- Joint Commission on Mental Health of Children Report
- The Law and the Mentally Ill
- Manpower
- Marital Counseling
- Strikes by Mental Hospital Employees
- Suicide Prevention
- Violence and the Mentally Ill

(Free on request from NAMH, 10 Columbus Circle, New York, N.Y. 10019)

New and revised pamphlets:

- Clergy: Clergyman's Guide to Recognizing Serious Mental Illness—Single copy free. \$6.50 per C
- Ministering to Families of the Mentally Ill—Single copy free. \$6.50 per C
- Pastoral Help in Serious Mental Illness—Single copy free. \$6.50 per C
- The Clergy and Mental Health—Single copy free. \$6.50 per C

- Facts About Mental Illness—Single copy free. \$1.87 per C

- Basic up-to-date statistics.

- Film Catalog (Selected Films for Mental Health Education)—free.

- Growin' Up Ain't All That Easy—Single copy free. 55¢ per C

- The need for services for mentally ill children.

- Guide for establishing an Information Service—25¢ each

- How to Deal with Mental Problems—Single copy free. \$3 per C

- Do's and Don'ts for dealing with the emotionally disturbed.

- How to Deal with Your Tensions—Single copy free. \$4 per C

- Eleven ways to deal with tensions.

- Insurance in Modern Mental Health Care—Single copy free. \$3.50 per C

- The current thinking concerning insurance coverage for mental illness.

- Mental Health Manpower Kit—\$2.50 per kit
- Contains the NAMH Statement on Manpower and 34 features mental health manpower programs covering examples of new

careers, new sources of workers (among them the disadvantaged) and innovative uses of volunteers. Can be used as a resource in developing new mental health manpower programs for universities, junior colleges, hospitals, clinics, community mental health centers, professional organizations and local mental health associations.

Mental Illness: A Guide for the Family (revised edition)—1-24 copies 50¢ each; 25th copy and all additional copies—35¢ each

Handbook for families of the mentally ill

NAMH Publications Catalog—free.

Pierre The Pelican Series—Single set \$1.00. \$25.00 per M without imprint. \$30.00 per M with imprint

A series of 28 pamphlets on child care for first-time parents

Joint Information Service Publications

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

Approaches to the Care of Long-Term Mental Patients—\$2.50 each.

General Hospital Psychiatric Units: A National Survey—\$1.50 each.

Health Insurance for Mental Illness—\$2.50 each.

Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems—(cloth) \$6.00 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

Private Psychiatric Hospitals: A National Survey—\$1.50 each.

The Community Mental Health Center: An Analysis of Existing Models—\$3.00 each. 5 or more copies \$2.50 each.

The Community Mental Health Center: An Interim Appraisal—(cloth) \$6.50 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

The Psychiatric Emergency: A Study of Patterns of Service, 1966—\$2.50 each. 5 or more copies \$2.00 each.

The Treatment of Alcoholism—\$3.00 each.

Legal Services and Community Mental Health Centers, Henry Weihofen, \$2.00 each.

The Staff of the Mental Health Center: A field study—\$6.00 (hardcover), 4-9 copies \$5.25, 10 or more copies \$4.75.

The Mentally Ill Offender: A Survey of Treatment Programs, Patricia K. Scheidemandel and Charles K. Kanno, \$2.00 each.

Reprints from MENTAL HYGIENE
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THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a co-ordinated citizens' organization working for the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis, and treatment of mental illnesses and handicaps; and for the promotion of mental health.

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